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ABSTRACT

The report describes a Federally supported education and development program conducted during the 1973-74 fiscal year for members of the Michigan State Health Planning Advisory Council. The program sought to increase: (1) the council members' awareness of and insight into the comprehensive health planning process, (2) their knowledge of the health care system, and (3) the ability and competency of the council as a planning group, thereby to increase their effectiveness in producing a State health policy. The evaluation of the program was aimed at discovering what happened to and for the Advisory Council and its members as a consequence of the educational effort. Lengthy discussion of findings from questionnaires, observations, and interviews indicates that the educational processes were generally successful, particularly in relation to relationships and dynamics within the group. Implications, based on council member testimony, are outlined. About 100 pages of appended materials include the evaluation instruments and sample project materials. (BP)

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AN EDUCATION AND DEVELOPMENT PROGRAM FOR
MICHIGAN'S STATE HEALTH PLANNING ADVISORY COUNCIL

August 1974

CE 004 320

A Report from the
Office of Health and Medical Affairs
Lansing, Michigan 48913

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TASK FORCE REPORTS

Task Force Reports developed in connection with the Advisory Council Education and Development Project are available from the Office of Health and Medical Affairs, Lewis Cass Building, Lansing, Michigan 48913.

Maternal and Child Health Task Force:

"Perinatal Intensive Care in Michigan - A Statement of Public Policy"

"Maternal and Child Health Services in Michigan - A Statement of Public Policy"

Medicaid Task Force:

"Medicaid and the Organization on Long-Term Care in Michigan - A Statement of Public Policy"

Health Cost Containment Task Force:

"Incentive Reimbursement: A Cost Containment Strategy in Michigan - A Statement of Public Policy"

SUMMARY

This report describes a federally supported education and development program conducted during the 1973-74 fiscal year for the Michigan State Health Planning Advisory Council. The program sought to increase Council members' awareness of and insight into the comprehensive health planning process and their knowledge of the health care system. It also sought to increase the ability and competency of the Council as a planning group and thereby increase the effectiveness of the Council in producing state health policy.

Methods chosen were applied to three Council task forces responsible for making policy recommendations during the project year as well as to the Council as a whole. In brief they included assessing the effectiveness of meetings and providing feedback of this information to Council members, conducting joint staff-Council member sessions to plan meetings and implement decisions, providing issue-focused written material to Council members and conducting discussions of materials, changing the array of physical aspects of meetings, collecting information with perception and role questionnaires and providing feedback of this information, providing primary consultants to maximize the technical knowledge available, distributing preliminary recommendations as a means to test their feasibility, maintaining a log of observations of interpersonal and procedural events, and timely sharing of these with staff and Council members, and interviewing all Council members to help them reflect on the nature of their experience.

Findings included: During the year Council members increasingly perceived that they were experiencing an educational process and taking responsibility for it and for the work of the Council. As a group the Council increased in each of four measured dimensions of socio-emotional climate. Member assessment of meetings were overall more positive than negative, and individual attitudes toward single meetings showed an apparent relationship to attitudes toward the long-term prospects of the Council. The results of the meeting assessments demonstrated an unpredicted regular pattern which if studied further could be a significant contribution to knowledge of group dynamics. The log, to the extent observations were accurate, showed the Council grew in intercommunication among members, objectivity toward its own functioning, interdependence of responsibility, cohesion, ability to inform itself and make decisions about problems, ability to detect and control group rhythms, skill in controlling factors in structure and functioning of the group, integration of individual ideologies, needs and goals, and ability to create new functions.

In addition, interviews of Council members at the conclusion of the program yielded a wide range of response concerning views members had of their roles in representing others and as consumers or providers, attitudes toward both written and verbally presented information, attitudes toward other members, Council meetings and staff, and how these attitudes changed during the year. Thirty-one of 39 members indicated that their experiences with the Council noticeably affected their professional or personal lives.

Implications, in the absence of an experimental research design, were based on Council member testimony and staff observations. They include:

- Group effectiveness can be increased by learning about group dynamics in the context of task-oriented activity.

The receptiveness of Council members to education and development activities is influenced by their perceptions of staff competence and support, and by the extent of their own participation in planning, implementation and evaluation of the activities.

- Adoption of a new practice is related positively to the perception of the new practice as helpful in moving toward task objectives and to having a group experience with the practice and negatively to staff skepticism about members' reactions.
- Active participation is influenced by the degree to which the leader is seen as being helpful, the person's own level of interest, a feeling of ability to influence results, and the degree to which the person is not overawed by the perceived expertise of other members.
- The resources of members who have heterogeneous backgrounds, roles, levels of expertise and assertiveness, sex, and lengths of tenure, are used most productively where there is training in group membership and frequent informal contact.
- In a task-oriented group, desire for interpersonal contact is likely to be present, but not clearly expressed. However, when recognized and provided for, it is a means to increase group identity and effective work relationships.
- Communication of selected information aimed at target questions and issues of immediate relevance is less likely to overload and overwhelm than large quantities of broadly relevant information.
- Effectiveness of group problem-solving and decision-making is enhanced by provision of a common technical vocabulary through such means as a glossary.
- In their initial charges committees need objectives as specific as possible in dimensions of time and quantity to avoid spending undue time and effort in establishing the perimeters of their work.
- Part-time consultants who are recognized as experts and who are reimbursed can provide an effective source of technical knowledge and vitality to committees of volunteers who have a variety of levels of expertise.
- Dissemination of preliminary recommendations can result in reactions from interested and affected groups and can prepare the way for consensus on desired change and methods to accomplish it.

Several current Council activities are being continued or have been developed because of the education and development program. These include health planning guidelines for Council committees and both orientation procedures for new members and ongoing education for all members based on program experiences.

I. DEFINING THE PROBLEM

Background

In the spring of 1973, certain assumptions about health planning advisory councils at the state level throughout the country, as well as experiences in Michigan, prompted the design of this education and development project. These were:

- that the impact of state health planning advisory councils on state health planning had been minimal; and
- that the ability of members of state health planning advisory councils to act effectively in a "partnership for health," as projected in federal legislation, had been limited.

Among the reasons for these assumptions, three stand out:

- often there was not a precise definition at the state level of the relationship of advisory councils to other components of the health care system - establishment of councils by federal legislation, without accompanying state legislation, contributed to the lack of precision;*
- some people in the health care system did not agree with or see the need for an integrating and overlying policy-making body; and
- the methods for producing state health policy and state health plans were in the process of being developed, but had not gained wide acceptance.

It was further assumed that council members' lack of knowledge, experience and perspective was in part responsible for their limited effectiveness.

Consumers generally lack knowledge of the health care system, its components, and how they relate; lack experience in working with providers in group settings; lack understanding of the role of consumers on such advisory bodies; and lack knowledge of and experience in comprehensive health planning.

Providers usually have sophisticated knowledge of a portion of the health care system, but generally do not have a broad knowledge of it; lack experience in dealing with consumer opinions and in working with heterogeneous groups to produce health policy recommendations; resist change in the status quo because of an appreciation of the complexity of the system and the difficulties in changing it or because of a conflict of interest, or both; and also lack knowledge of and experience in comprehensive health planning.

* A survey of state comprehensive health planning agencies by William J. Waters at Ohio State University in April 1974, reported that of the 42 (of 50) agencies which responded, 12 or 29 percent had statutory authority from state government by way of legislation "tailored specifically for CHP." Final analysis is contained in a dissertation completed in August 1974.

The Situation in Michigan

The evolution of comprehensive health planning at the state level in Michigan has been marked by a series of organizational struggles and by gradual achievements in planning and policy development. Shortly after enactment of P.L. 89-749 in 1966, Governor George Romney created an Advisory Council in the Executive Office and a Comprehensive State Health Planning Commission composed of the State Budget Director, an executive assistant to the Governor, and the directors of the Departments of Public Health, Mental Health and Social Services with the primary assignment to serve as Michigan's long-range interdepartmental health planning agency."

The success of this approach to comprehensive health planning was understandably limited. The Commission was made up of individuals who had clearly defined jurisdictional interests to protect. In describing the work of the Commission, one member said, "Controversial issues were avoided and decisions postponed."

In 1970, Governor William G. Milliken reorganized the state comprehensive health planning agency, creating an Office of Comprehensive Health Planning, which was given major responsibility for health policy planning. The Commission was made a technical advisory body, while the Council became advisory to both the Office and the Commission. This reorganization provided the agency and the Council an opportunity and an obligation to participate directly in the formulation of public policy.

Throughout the next months, the Advisory Council began to examine a variety of health care problems. The Office, though, faced major difficulty in finding and recruiting personnel with the knowledge and flexibility needed to staff the Council and to manage this change in direction.

In the next two years, other attempts were made to increase the effectiveness of state comprehensive health planning. However, the Governor recognized that fulfillment of the role which he envisioned for the agency would require a different kind of leadership and a stronger mandate. In November, 1972, he abolished the Office of Comprehensive Health Planning and the Commission, creating the Office of Health and Medical Affairs. In the spring of 1973, a new Advisory Council was appointed which retained some members of the previous Council.

The role of the new Office in formulation of public policy and health planning was clarified:

"The Office of Health and Medical Affairs shall serve as the focal point for health advice to the Governor, including matters of policy, and will have the principal responsibility for planning, monitoring and coordinating the utilization of all health resources under the control or influence of state government."*

This clarification was instrumental in breaking down barriers to recruitment of adequate staff, which in turn allowed for further development of comprehensive health planning in Michigan. The Advisory Council education and development project was designed to enhance this process.

* Executive Order 1972-12.

The grant request for the project points out that in Michigan in the spring of 1973, the highest priority in the Office of Health and Medical Affairs was placed "on rendering advice and consultation to the Governor on critical health issues." "It was of utmost importance," the request stated, "that the Advisory Council, in order to assist in this task, be knowledgeable about health matters and capable of discharging its advisory function in a sound manner." Further, concern was expressed that unless the consumer component of the Advisory Council was strengthened by information and education, only interests of providers or professional groups would be served.

Previous experience in Michigan in work with citizen planning and advisory groups in the health field indicated that effectiveness appeared to be related to:

- knowledge about comprehensive health planning processes;
- knowledge about the health care system;
- knowledge of group processes;
- competency as a planning group;
- acceptance by providers of the importance of consumer participation; and
- adequate staff support.

In designing the project, other assumptions were made which affected the overall goal of the project and which underlay specific elements in it.

- The Governor's Executive Order which created a new Advisory Council and the Office of Health and Medical Affairs would provide an opportunity for the development of a more effective state health advisory council. The grant request refers to the "unique opportunity to develop new methodology for structuring the activities of the Council in the formulation of state health policy."
- It was feasible to conduct an education and development project with such a Council and that the anticipated results warranted the attempt. Other possible courses, such as developing procedural manuals, were rejected.
- Because Advisory Council members were appointed by the Governor to advise him and the Office of Health and Medical Affairs and to make recommendations about state health policy rather than to be "educated and developed" by a federally funded training grant project, methods to be employed in the project would be tied directly to current policy-making responsibilities. Timing of the grant request coincided with a request from the Governor to the Advisory Council to develop state health policy in three areas: "extension and improvement of health services to mothers and children; more effective and efficient administration and conduct

of the Medicaid program; and measures directed toward cost containment in the health care field."*

- Learning about comprehensive health planning processes, through the use of health planning methods to develop policy in three subject areas, is transferable to other areas. The grant request states that expectation that "benefits of the educational experience will extend far beyond the one year program, for the Council will be able to utilize health planning processes throughout its deliberations."
- Adequate staff and needed services would be available. The grant request included the intention to obtain consultation on use of methods and techniques designed to increase the effectiveness of Advisory Council meetings and subgroup meetings, and of Advisory Council members as individual participants in the health planning process. Consultant services in three subject areas and the possibility of contractual arrangements with outside groups to obtain additional information in the short time available were planned. A full-time staff planner for each of the three Advisory Council task forces, provision of evaluation services, an associate project director and adequate secretarial support services were also part of the design.
- Reasonably effective means were available to evaluate the project. Again, the grant request stressed the tie to production of acceptable state health policy as one measure of effectiveness. In addition, the "usefulness of the educational process and the effectiveness of the various methods. . . as educational tools" were to be assessed.

* Letter from the Governor to the Acting Chairman of the Advisory Council, dated April 19, 1973, see Appendix A.

II. PLANNING THE EDUCATION AND DEVELOPMENT PROJECT

Objectives

The project plan was developed in three phases: preliminary and broad directional planning done at the time the grant request was prepared; operational planning that went on during recruitment of staff and establishment of Advisory Council task forces; and a third and much more detailed planning effort the grant staff and consultants engaged in during initial stages of the project year.

As refined in the third phase of the process, the objectives of the project were:

- to increase Advisory Council members' awareness of and insight into the comprehensive health planning processes;
- to increase their knowledge of the health care system, in general, and to increase their knowledge specifically in three substantive areas of the health care system;
- to enhance their ability, perspective and attitudes regarding their role as Advisory Council members;
- to increase the competency of the Advisory Council as a planning group; and
- to increase the Advisory Council's effectiveness in producing state health policy.

Each of these objectives was further defined as follows.

Awareness of and insight into comprehensive health planning processes encompassed a variety of aspects including providing effective roles for both consumers and providers. Emphasis was placed on designing opportunities for work with existing governmental and nongovernmental groups involved in the health care system. Development of alternate means for reaching solutions to problems was stressed. Recognition of how Advisory Council decisions are related to the public accountability and social responsibility in the health care system and recognition of the strengths of the system as well as its problems was expected. It was anticipated that the project would provide experiences which would demonstrate major areas of agreement between consumers and providers and between the public and private sectors regarding needed changes. In addition, understanding and acceptance of the need for evaluation of the results of Advisory Council decisions and recommendations was expected.

Increased knowledge of the health care system and of the three substantive areas within the system included aspects beyond the obvious accumulation of additional information. A better understanding of the interdependence of various sectors of the system and an appreciation of the complexity of problems involved in improving health and the provision of health care services was

expected. Further, appreciation of the fact that this interdependency and complexity are incompletely understood, even by experts in the field, was desired.

The objective of enhanced ability, perspective and attitudes of Advisory Council members regarding their role as members of the Council was linked to objectives of increased competency of the Advisory Council as a planning group and the Advisory Council's increased effectiveness in producing state health policy.

Among many aspects of these three closely related objectives, the project was designed to assist individuals, subgroups, or the group as a whole to:

- ask inquiring and clarifying questions;
- encourage others to participate;
- use the work of other groups and individuals;
- recognize when to ask for outside assistance;
- appreciate the importance of political, technical and economic factors in the feasibility of their recommendations;
- recognize that, even when solid information is available, often value judgments must be made requiring a choice between legitimate competing values;
- understand that in addition to policy recommendations, a wide consensus of support for needed action and responsible leadership is essential in providing for implementation of recommendations; and
- understand that Advisory Council decisions in part affect the roles of state government, state and areawide health planning agencies and nongovernmental groups in the health care system.

Methods

The methods chosen to meet these objectives were varied. Some of the methods were modified during the project year to meet particular needs of each Advisory Council task force as well as to respond to evolving needs of the Advisory Council as perceived by the staff of the Office of Health and Medical Affairs, consultants and Advisory Council leadership. Delineation of the methods used is integrated into the section of the report which describes the project as it actually took place (Chapter IV). Many methods served more than one objective and some, which were designed primarily to evaluate the project, were useful in other ways as well.

Evaluation

Evaluation of the project was based on the use of six different methods by which information was obtained. These each contributed to an overall analysis

assessing the extent to which the Advisory Council as a group and members as individuals changed along several dimensions. On some dimensions, the project was intended to influence change in one direction rather than the other. On other dimensions, there was uncertainty about whether change was desirable and if so, which was the desired direction.

A detailed discussion of the instruments and procedures used, the dimensions for evaluation, and the findings and their interpretations are included in the evaluation section of the report (Chapter V). Data sources for the evaluation effort include:

- role definitions by Advisory Council members;
- assessment of socio-emotional climate by members of Advisory Council and task forces;
- meeting evaluations by Advisory Council members;
- observations of Advisory Council meetings;
- interviews of Advisory Council members; and
- actions taken related to Advisory Council recommendations on state health policy.

III. CONDITIONS AFFECTING THE DESIGN AND CONDUCT OF THE PROJECT

Several conditions provided parameters to the design of the project initially, and others, which developed during the project year, changed its conduct once underway. Some conditions were fixed in advance, others resulted from deliberate planning and still others developed inadvertently.

Because, in large part, the value of reporting on a project such as this lies in the transferability of the experiences and what was learned to other similar settings and to future efforts of this particular Advisory Council, a description of the circumstances in which the project was designed and conducted is included.

Advisory Council

Several aspects of the Advisory Council were pertinent, especially the fact that it was a new Council replacing a previous one. There was a one-third overlap between membership in the previous Council and the new one. It also had an expanded charge. This very newness provided fertile ground for the proposed education and development project. It also reduced the likelihood that such a project would be questioned or challenged and undoubtedly was a factor in the acceptance by the Advisory Council of the existence of the project, which was funded shortly after the Advisory Council had its first meeting.

The size of the Advisory Council, 41 members, and the proportion of consumers to providers, 51 to 49 percent, was fixed. The Departments of Public Health, Mental Health and Social Services, the Veteran's Administration Hospitals, and the Michigan Association for Regional Medical Programs were given representation by federal legislation or the Executive Order. Appointment of members of other governmental and nongovernmental organizations and groups concerned with health had been made (see Appendix B). In addition, the Chairman had been appointed by the Governor and the Chairman had designated an Executive Committee.

Only after the Advisory Council began to perceive its possible effectiveness as a group was the issue of whether or not a member represented a group or participated as an individual discussed. This was further delineated during discussions about the federally required conflict of interest statement. Consensus was reached that, with exceptions specified in the federal law and the Governor's Executive Order, Advisory Council members serve as individuals. This decision in turn may have been a factor in the Advisory Council reaching agreement on several relatively controversial issues at the end of the year. Other circumstances, such as voting as representatives of specific constituencies, might have provided grounds for more disagreement.

The project staff perceived the Advisory Council members as having certain initial expectations about their role as advisors to the Governor and the Office of Health and Medical Affairs, and about their activities. There was a certain amount of resistance by Advisory Council members to presentation of information by staff and consultants at the first few meetings, both about the health planning process and about task force problem areas. The

emphasis on presentation of information rather than on their participation as advisors was of concern to many. It was not until the Advisory Council faced increasingly difficult and technical aspects of the planning process within the task forces, and later the prospect of being required to produce a state health plan, that changes in these expectations were apparent. Some expressed the need to learn more about the health care system and how it operates, the feasibility of possible solutions to problems and whether or not meaningful change is possible. A few members withdrew at this point from most task force meetings or from both task force and Advisory Council meetings, which may have been their response to being placed in a situation requiring more learning or more time.

Other general and sometimes vague expectations by Advisory Council members about operation of the Advisory Council also changed during the year, becoming more specific and requiring action by the Advisory Council itself, the Council's Executive Committee, or the staff. For example, the role of the Executive Committee was increased and clarified, and the frequency of Advisory Council meetings changed from every two months to monthly.

Although all activities of the Advisory Council came under the perview of the project, insofar as they related to educational and developmental objectives, the Advisory Council did conduct other business beyond the work of the three task forces and activities designed as part of the project. This other business provided limits to the time and energy available for project activities. Examples include:

- consideration of current legislation, both state and federal, and decisions to support, suggest modification or deny support;
- review and comment on a wide variety of grant requests; and
- consideration of reports and recommendations from another task force, several committees and three work groups.

Throughout, the expectation was that the Advisory Council would produce state health policy recommendations, with supporting material in the form of reports, for the Governor. This expectation was shared by Advisory Council members, consultants and staff. Further, it was anticipated that upon acceptance by the Governor the recommendations would become state health policy.

Task Forces

Predetermined conditions related to the three task forces included the request to the Advisory Council by the Governor for recommendations in three areas and the method of forming task forces. The three-part charge naturally fell into three work group efforts. Because the education and development project was intended to affect all Advisory Council members and was designed to use the three work areas as a vehicle, members were asked to choose one of three areas. They divided into these groups, with the Chairman not participating.

Maternal and Child Health - 12 members

Medicaid - 9 members

Health Cost Containment - 19 members

The Executive Committee decided not to equalize membership in the task forces and subsequently appointed chairpersons for each. This method of forming task forces resulted in an uneven distribution of consumers and providers and an uneven inclusion of available technical expertise, but did capture the benefits of choice and, presumably, motivation.

These factors in task force formation contrast with the methods used in forming other work groups of the Advisory Council. Other work groups often include non-Advisory Council members, are formed by direct Advisory Council initiative or at the instigation of the Office of Health and Medical Affairs, and a chairperson is chosen first, with the members added by asking for volunteers or by asking individuals to participate.

Project Design

The initial project design fixed certain conditions which affected the conduct of the project. Despite benefits derived from timing, an education and development project to coincide with the beginning of a new Advisory Council, the timing did preclude Advisory Council participation in the decision to apply for and then to accept the grant for the project. Had Advisory Council members discussed and then voted to apply for and accept the grant, their understanding of the project and willingness to become involved would perhaps have been at a higher level initially or accelerated in development.

A second set of conditions was fixed by the period of time, one year, for which monies from the 314(c) source were to be available. One year placed a restricted time schedule on all aspects of the project, especially on production of final reports and evaluation activities. By the time it became apparent that any remaining money might be able to be used to extend the grant period various steps were already locked into the one year scheme, not the least of which was expectation of producing state health policy recommendations for the Governor by the year's end.

Staff

Because of the desirability and necessity to budget in advance, staff available for the project was determined for the most part at the beginning of the project. In addition to a part-time associate project director directly responsible to the Director of the Office of Health and Medical Affairs, there was a part-time educational consultant for the project, full-time staff planners for each task force, part-time primary technical consultants to each task force, outside consulting groups used for specific data gathering and secretarial support.

State Health Plan

All state comprehensive health planning agencies are expected to be working on or to have produced a state health plan. These expectations in Michigan provided conditions affecting the project as it progressed.

In Michigan, the state health plan is not conceived to be a single document produced at one time but a series of state health policy statements from the Advisory Council, with their supporting materials, studies and accompanying recommendations produced both by the Advisory Council and by the

Office of Health and Medical Affairs staff, and materials from other groups in the state. At any one time, existing reports and a state health plan framework to which they can be related constitute the state health plan. In this way, the framework can be continually modified as necessary, reports can be updated when necessary and gaps can be identified and dealt with. Relationships between sections of the plan can also be changed to reflect changes in the health care system as well as to prompt them.

The education and development project was tied directly to production of state health policy recommendations and reports in three areas. These were intended then to become part of the state health plan. Because of this fact, the products of the task forces needed to have relatively parallel formats, methods and timetables.

In addition, the education and development project capitalized on Advisory Council members' increasing interest in and concern with what a state health plan is and how it is produced. The project was modified to include a workshop on "What Is a State Health Plan?" and, using the project staff including consultants, to design an orientation and overview meeting for both new and old Advisory Council members to be conducted at the time new members are appointed. This will include further education on the state health plan and on how it will be developed.

IV. A DESCRIPTION OF THE PROJECT

Organizational Steps

The first meeting of the new State Health Planning Advisory Council in May of 1973, marked the beginning of the Advisory Council education and development project. In anticipation of funding, the project was explained, the Governor's letter to the Advisory Council requesting "development of a state policy on the extension and improvement of health services to mothers and children, recommendations concerning the future development of the Medicaid program and development of measures directed toward cost containment in the health care field" (see Appendix A) was read and discussed, and a plan for forming three task forces was presented.

The educational consultant for the project was introduced, and he explained the meeting evaluation form (see Appendix B) to be used at each Advisory Council meeting, pointing out that a summary of members' responses regarding each meeting (see Appendix B) would be made available and discussed at succeeding meetings throughout the project year. A summary comparing consumer and provider responses was added at midyear (see Appendix B).

Between the May and July Advisory Council meetings, a request was mailed to members asking them to choose one of three task forces. When the rosters were complete, the Executive Committee chose a chairperson for each task force from among its members.

At the July Advisory Council meeting, the membership and chairperson of each task force was announced, the grant award (see Appendix A) was confirmed, and proposed staffing for the project was explained. After the meeting, the three task forces met to discuss their charges. Possible objectives and accomplishments of task force work programs within the time limit of one year were also explored.

Simultaneously, the balance of the staff was recruited, consultants engaged and further exploration of possible methods undertaken.

Initial Activities: Advisory Council

Formal procedures were instituted for evaluation of Advisory Council and Executive Committee meetings and for the design of succeeding meetings by the educational consultant, with the assistance of the associate project director and staff planners:

- At the lunch recess of each Advisory Council meeting, assessment forms were distributed to members' places. The Chairman called attention to the forms after the meeting resumed, requesting that they be completed and handed in before leaving.

- At the beginning of each Advisory Council meeting, a report on the assessment of the previous meeting and cumulative summaries were discussed by the Chairman, with assistance from the educational consultant. The Chairman used this opportunity to point out changes made as a result of suggestions by members, as well as using assessment summaries to guide him in conducting meetings.

--An Advisory Council meeting planning session was held one to two weeks prior to each meeting and after the Executive Committee had approved a proposed agenda. Both the Chairman of the Advisory Council and the Director of the Office of Health and Medical Affairs, who share the leadership role at Advisory Council meetings, attended these planning meetings along with the educational consultant, the project staff and the Assistant Director for Planning who is responsible for Advisory Council activities. Data from meeting evaluation forms and from observations of the educational consultant were used, and alternate and sometimes novel methods for handling aspects of the upcoming meeting were discussed. Physical arrangements, means to increase consumer participation, methods to control the time spent on agenda items, voting procedures and anything else pertinent to the meeting and to the education and development project were determined.

At the third Advisory Council meeting the grant staff, at the suggestion of the education consultant, used a "Yes-No?" form (see Appendix B) in the discussion and voted on an early set of recommendations from one task force. This was well-received by Advisory Council members, some of whom requested a similar procedure at the end of the year when considering the major portion of recommendations.

The educational consultant and project staff, after a series of discussions on the use of questionnaires, made decisions which lead to these procedures:

- An Advisory Council group perception questionnaire and a task force group perception questionnaire (see Appendix B) were administered to all Advisory Council members in November and again in May. These were mailed with a cover letter from the Advisory Council Chairman.
- An Advisory Council role perception questionnaire (see Appendix B), developed by the staff, was administered at the same time as the group perception questionnaires.
- A questionnaire to test current knowledge of the health care system and of health and health planning concepts was discussed, preliminary work was done; and then a decision was made not to use such an instrument. This decision was based primarily on two points. By the time such a questionnaire could be developed and tested, too much of the project year would have elapsed to allow for administering it twice; and, more importantly, a general reluctance on the part of the staff was expressed to testing the knowledge of the Advisory Council either with or without their prior consent. This reluctance reflected the way in which staff viewed Advisory Council members' perception of their role as advisors.

Materials on the health planning process were distributed and discussed at both Advisory Council and task force meetings. These were developed in two stages; a preliminary, short version (see Appendix C) of the step involved, and a more extensive version which was presented after the task forces had begun to explore their problem areas (see Appendix C). A

definition of state comprehensive health planning was also distributed and discussed (see Appendix C). In addition, project of objectives and testing and evaluation procedures were described by the educational consultant and discussed by the Advisory Council.

A chronological chart, recording all major project-related activities, was kept by the project staff (see Appendix C).

Initial Activities: Task Forces

Each task force chairperson and staff planner, by design of the project staff, placed strong emphasis on the need to limit task force objectives because of the severe time restriction. In each of the three cases, the original charge was determined, both by staff and later by the task forces, to be too broad to be adequately completed in one year. Accordingly, objectives which would only partially fulfill the charge were chosen by each task force.

The task force chairpersons, associate project director, educational consultant, staff planners and primary consultants, as appropriate made decisions regarding:

- design of meetings;
- which resource materials, groups and individuals to use; and
- specific work of the primary consultants.

Decisions on means to provide to the Advisory Council as a whole educational materials and experiences about the three task force subject areas were also made with the participation of task force chairpersons. Primary consultants, chairpersons and resource people were used as presenters and as discussion leaders. It was deemed desirable to conduct such educational efforts in advance of the times at which the Advisory Council would have to act on specific task force proposals. The basic plan was to mail or distribute to the Advisory Council as a whole reading material, and then to provide a minimum of three opportunities to discuss issues involved in each subject area: First at an early Advisory Council meeting, then when preliminary recommendations were proposed, and finally when final action was taken on final recommendations. Executive Committee meetings also were used to provide briefings on task force areas of concern in advance of Advisory Council meetings.

A brainstorming session (see Appendix C) was designed and conducted by the project staff for purposes of expanding the list of possible issues within each task force subject area and developing lists of all possibly pertinent outside groups and individuals which could be contacted either as information sources, participants in the planning process or reactors to preliminary recommendations. Staff of the Office of Health and Medical Affairs, project consultants and other selected resource people participated.

Each task force staff planner made an effort to meet with each task force member on an individual basis. This was planned to give task force members an opportunity to discuss, outside the group, their perceptions of the job ahead and to allow the staff planner to offer assistance, particularly to consumer members, in providing background material when desired and to accelerate the get-acquainted period. Approximately one-half of the members were not seen because of constraints on staff time and because of geographical distances involved.

Initial Activities: Maternal and Child Health Task Force

At their initial meeting in July, the Maternal and Child Health Task Force was faced with a request for recommendations and a report on perinatal intensive care services by September. The time constraint was necessary so that the plan could be used as the basis for state budget decisions for the 1974-75 fiscal year. The Advisory Council was briefed on the subject area and issues involved at the July meeting, and the task force and staff worked with a variety of consultants and resource people, especially those in the Department of Public Health, in succeeding weeks. The task force developed a series of recommendations, and the staff planner wrote a report, both of which were accepted by the Advisory Council in September and by the Governor in October.* (Throughout the late fall and the first half of 1974, the published report was given wide distribution in the state.)

The task force's work was not completed at that point, however, since the original charge to the task force was much broader than developing policy recommendations for perinatal intensive care services. It asked for recommendations to extend and improve health services to mothers and children. Also, concern was expressed by Advisory Council members about the recent Supreme Court decision on abortion and the resulting need within all states to assure adequate and safe pregnancy termination services.

In succeeding meetings, the task force discussed a variety of maternal and child health issues and polled members for individual priorities. Assuring quality for abortion services, how maternal and child health policy will relate to a comprehensive state health plan, and the health planning process in relation to development of a policy statement on maternal and child health were also discussed. Decisions were made on the rank ordering of priority issues and on a format for presentation of maternal and child issues at the next Advisory Council meeting.

After that Advisory Council meeting, the presentation and format as educational experiences were discussed with mixed opinions on effectiveness. In succeeding task force meetings, discussion of the feasibility of possible recommendations regarding priority issues was followed by further refinement of top priority issues. Data and information from a variety of sources were used. A possible

*"Perinatal Intensive Care in Michigan - A Statement of Public Policy,"
Office of Health and Medical Affairs, October 1973.

"philosophy of maternal and child health" was discussed. Various measures of health status were explored and a draft outline to be used to describe the health status of mothers and children and services currently available was developed.

The task force decided to place primary emphasis on reducing the fragmentation of primary health care services for mothers and children in Michigan. Additional issues were raised regarding the assurance of quality care in abortion services and the relationship of family planning services to health care in general. A third area identified by the task force for consideration was the organization and delivery of school health services.

Initial Activities: Medicaid Task Force

The task force charge to make recommendations for more effective and efficient administration of the Medicaid program, and the possible issues involved, were explored in initial meetings. The need for outside information and opinion, especially from consumers of Medicaid financed services was recognized, and a decision was made to write letters (see Appendix C) from the task force to a wide variety of groups asking for this help rather than to conduct public hearings because of the time constraint.

Resource people from the Department of Social Services and the primary consultant reported on the current status and problems of the Medicaid program; worksheets were used to help focus individual concerns; presentations on provider attitudes and the administrative status of the program were made; decisions were reached on data needed; and a presentation of Medicaid issues at an Advisory Council meeting was planned.

At succeeding meetings, responses to the letters to outside groups were categorized and reviewed, data and information distributed and discussed, and priority areas determined.

As the planning process continued, more data were obtained and round-table discussions were held with a variety of people involved in the subject area to explore political realities and economic factors related to possible solutions to Medicaid problems. It became evident to task force members that to make recommendations for changes in the total program would be unrealistic; however, they decided to make a general recommendation and statement in their report encompassing these concerns.

By the end of this phase, the task force recognized that nursing home care used the largest portion of Medicaid funds. They, therefore, decided to investigate ways to improve long-term care.

Initial Activities: Health Cost Containment Task Force

This task force, like the others, used initial meetings to consider its charge which was to recommend measures directed toward cost containment in the health care field, to explore the issues involved in rising costs and to attempt to determine possible objectives. During several discussions, major factors in

increasing costs were identified and considered. The obvious need to limit what it would attempt to do prompted use of a questionnaire to members soliciting their priority issues (see Appendix C).

Background materials were identified and reviewed; discussions held with resource people, including the principal author of a recent state publication, Rising Medical Costs in Michigan*; further data needs were identified; responses to the questionnaire were used to focus discussions on ranking priorities by use of a second questionnaire (see Appendix C); and a presentation was made by a consultant of other issues in the health delivery system which have implications for cost containment.

Two major presentations and discussions followed the exploratory phase: a report on the major policy areas influencing cost containment by the primary consultant and a proposal by an outside organization (National Sanitation Foundation) for a computer model simulation of cost containment factors. In addition, influence of the Hospital Finance Authority Act, Certificate of Need legislation, and costs of medical education were discussed and a paper on the organization of health cost containment priorities was presented.

Because of the technical nature of the issues and material involved, a health cost containment conference was held to discuss and rank problem areas and to make recommendations to the task force on priority issues. The task force chairperson, project staff, Office of Health and Medical Affairs' planning and research staff, and the primary consultant met with a group of outside consultants assembled for this purpose. In addition, available health cost data and data needs were discussed. A decision was made to recommend that the computer simulation proposal be rejected at this time, due to time constraints and the need to limit objectives.

The task force then chose to develop policy recommendations regarding incentive reimbursement of hospitals as a major means to contain health cost variables, which was reported to the Advisory Council at the time the task force made its initial educational presentation to the Advisory Council.

Mid-Point Activities: Advisory Council and Task Forces

Several actions were taken which continued to assist the Advisory Council in defining its role and that of individual members, although most activities had other purposes as well:

* Rising Medical Costs in Michigan: The Scope of the Problem and the Effectiveness of Current Controls, State of Michigan, Department of Social Services, Technical Work Group on Health Care Costs, July 1973.

- How task force reports would be integrated into the state health plan was discussed.
- State Health Planning Agency Performance Standards,* made available by the federal government in connection with the federal assessment of comprehensive health planning agencies, were distributed and discussed.
- A workshop, preceeding an Advisory Council meeting, on "what is a state health plan" was designed and conducted.
- A memo on the definition of responsibilities for development of a state health plan (see Appendix C) was distributed and discussed.
- A proposed format for the plan (see Appendix C) was distributed and discussed.
- Task force progress reports were presented to the Advisory Council by the chairpersons and to the Governor by the Principal Advisor on Health and Medical Affairs (see Appendix C).
- Priority issues, and why and how they were chosen, were discussed.
- An interim project report** to task force chairpersons, consultants etc., was prepared and distributed.
- Contact was made with the ten areawide comprehensive health planning agencies to report task force progress, request assistance and ask that they be prepared to review and comment upon preliminary recommendations. (see Appendix C).

Other activities during this period were related directly to the project:

- Results of the first group and role perception questionnaires were reported to and discussed by the Advisory Council.

*The Comprehensive Health Planning Service, Bureau of Health Resources Development, Health Resources Administration, U.S. Department of Health, Education, and Welfare, November 1973.

**"Interim Report on the 314(c) Grant: Advisory Council Education and Development," Office of Health and Medical Affairs, January 1974.

- Information was collected at the end of the state health plan workshop for evaluation purposes.
- A roll call and formal approval of the agenda were added to the beginning of Advisory Council meetings to enhance the sense of participation and endorsement of what was occurring.
- A glossary (see Appendix C) of health related and health planning terms was developed and distributed at the request of the Advisory Council.
- Contact was made with Advisory Council members who had poor attendance records to explore reasons and either increase attendance or prompt resignation (see Attendance Record).
- A plan to interview all Advisory Council members as a part of the evaluation of the project was explained at an Advisory Council meeting and four interviewers were introduced.
- The procedure used to appoint Advisory Council committees was modified to increase Council member participation in the process.
- A committee was appointed to recommend methods to increase consumer participation in Advisory Council proceedings.

The Final Phase: Generation of Preliminary and Final Recommendations

As the deadlines approached for formulation of preliminary recommendations, the use of resource people was accelerated, both in meetings with staff and task force chairpersons and as providers of information to task forces. Task force timetables were revised to make the best possible use of the remaining time, staff planners began to draft task force reports which would support the recommendations, and further presentations were made to the Advisory Council about considerations surrounding priority issues and reports of progress.

Preliminary recommendations would be subject to modification by the task forces after receiving suggestions from the Advisory Council and from a wide variety of groups and individuals throughout the state. They also would serve to familiarize Advisory Council members with the issues they would vote on in the final recommendations. Therefore, attempts were made to draft preliminary recommendations as forcefully and definitively as possible, with the expectation that modification was possible and even desirable.

After the task forces had drafted preliminary recommendations, the Office of Health and Medical Affairs staff reviewed them and made suggestions to the task forces on:

- coordination of recommendations with those of other task forces and committees of the Advisory Council;
- feasibility, in relation to the current political climate;

- wording, for clarity and accuracy;
- addition of who is to take the recommended action and when, wherever possible; and
- review and suggested modification of the justification for each recommendation.

Preliminary recommendations of each task force, with a brief justification of each, and a statement of the problems and objectives they addressed were then mailed to Advisory Council members and to appropriate outside groups and individuals. Cover memos and lists of these contacts for each task force are in Appendix C.

Each task force chairperson, assisted by the staff planner and primary consultant, led a discussion of preliminary recommendations at an Advisory Council meeting. The results of these discussions, plus the responses from outside groups and individuals and continuing discussions with the primary consultant, outside consultants and resource people were considered by the task forces in modifying the preliminary recommendations. Changes were made, occasionally a recommendation was dropped or one added, and in the case of one task force, a minority report was submitted. Drafts of task force reports were also reviewed by the task forces and modifications suggested to the staff.

Final recommendations, with a draft of the report, were then mailed to Advisory Council members. Worksheets (see Appendix C) were sent to Advisory Council members with the final recommendations to assist them in both their study of the material before the Advisory Council meeting and the discussions at the meeting.

At the succeeding Advisory Council meeting, each chairperson, again assisted by the staff planner and primary consultant, went through each recommendation, a discussion of it and a vote on it. Although most recommendations remained unchanged and received unanimous support, Advisory Council members did take this final opportunity to change some recommendations. Not all recommendations were supported unanimously, and a few were not accepted.

Ballots were prepared in advance to provide the Chairman with as many options as possible in handling the voting procedure. They were available at the meeting to be used there or to be taken home and mailed in within a week, at the Chairman's discretion. As it happened, each recommendation was voted on by voice, so ballots were not necessary.

Final steps in the work program were then taken:

- The three reports were completed and edited. Each report, containing recommendations for state health policy, was sent to the Governor. Upon his endorsement, they are to be published and distributed throughout the state to interested groups and individuals.
- The evaluation of the project was completed.
- The project report was drafted, edited and will be distributed to the Advisory Council, the granting agency and appropriate groups and individuals.

V. EVALUATING THE PROJECT

Introduction

Much thought and action were directed toward facilitating growth, change and achievement in Advisory Council members as individuals and in the relationships and interactions between members as a group. As a result of this effort, it was hoped that Advisory Council members would individually and collectively become more competent as health planners. The educational efforts centered mainly on increasing Council members' knowledge of selected health issues and the process of health planning; raising their awareness to issues and skills in interpersonal interaction, communication, deliberation, and decision-making; and furthering their responsibility and risk-taking in health planning. Evaluation of the project was aimed at discovering what happened to and for the Advisory Council and its members as a consequence of these educational efforts. Data came from six sources. Each source is described in detail below. The findings from each source are then presented and interpreted.

Data Collection Methods and Procedures

The "Role of a Council Member" questionnaire (see Appendix B) was mailed to all Advisory Council members in November 1973, and again in May 1974. It was developed as a means to identify, clarify and increase commitment to 15 functions, as well as a means to collect data on members' perceptions of their roles and responsibilities. Advisory Council members indicated the extent to which they agreed, on a five point scale, that each function was an appropriate one for members to perform. Responses were weighted so that the most agreement received the highest score and the least agreement received the lowest score.

It was the project staff's assumption that the more that members agreed to feel responsible for all 15 functions, the more fully functioning and effective the Advisory Council would become as a health planning group. Responses were made anonymously with self-assigned code numbers to allow comparison between individual responses in November and May.

The "Advisory Council Inventory" and the "Task Force Inventory" (See Appendix B) were adapted from the Group Perception Inventory, initially constructed in 1965 by the Human Development Institute, Atlanta, Georgia. The inventories were mailed to Advisory Council members (with the role questionnaire) in November and May to collect mid- and post-data on the socio-emotional climate existing within the Advisory Council as a group and within task forces as subgroups. It was also intended to raise the consciousness of Advisory Council members regarding four dimensions of socio-emotional life in groups. The dimensions of climate assessed by each of the two instruments are genuineness, understanding, valuing, and acceptance. Each dimension is best defined by the four items which comprised it in the Inventory:

genuineness - level with me
 feel free to let me know when I irritate them
 keep things to themselves to spare my feelings
 be completely frank with me

- understanding - get the drift of what I am trying to say
perceive what kind of person I really am
misconstrue things I say or do
recognize readily when something is bothering me
- valuing - include me in what's going on
be interested in me
interrupt or ignore my comments
respect me as a person apart from my skills or status
- acceptance - accept me for what I am
act "judgmental" with me
ridicule me or disapprove if I show my peculiarities
provide an atmosphere where I can be myself

Information for scoring the inventories is in Appendix B.

The project staff held the assumption, which is in line with most contemporary group development knowledge, that the more the conditions of genuineness, understanding, valuing, and acceptance existed within the Advisory Council and the task forces the more fully functioning and effective the Council would become as a health planning group.

The "How Did We Do?" questionnaire (see Appendix B) was distributed at Advisory Council meetings from May 1973 through February 1974, for members to complete and return. In response to members' requests for an instrument with a different response format, the "How Did It Go Today?" questionnaire (see Appendix B) was used at meetings from March through June 1974. Attitudes and perceptions regarding six aspects of group and individual functioning were assessed by both instruments. These were: feeling of positiveness or negativeness about the day's meeting, feeling of positiveness or negativeness about one's own participation, perception of how much work was accomplished during the day's meeting, clarity of perception of the Advisory Council's purpose, clarity of perception of one's own role as a member, and feeling of optimism or pessimism toward the prospects of the Advisory Council.

The second questionnaire added the assessment of five more attitudes and perceptions. These were: feeling of positiveness or negativeness about being a part of Council that day, feeling of investment in what Council was doing that day, level of understanding of what was happening at the meeting, feeling of influence in the day's session, and perception of the extent to which members seemed to listen to each other. In addition, it allowed staff to separate consumer and provider responses in order to compare attitudes. Each item was responded to on a six point scale, the most positive response earning six points and the least positive earning one point. Both questionnaires provided opportunity for additional comments at the bottom of the sheet.

Consistent with psychological knowledge regarding the relationship of understanding, optimism, shared power, productivity, and positive perspective to team effectiveness, the project staff viewed higher scores on each item as depicting a more fully functioning and effective planning group. As with other assessment instruments, these post-meeting reaction questionnaires were employed to increase member sensitivity to group process issues as well as to collect evaluation data.

A log of observations of interpersonal and procedural events at each meeting, maintained by the educational consultant, and the responses of members to open-ended questions on the two post-meeting reaction questionnaires provided much qualitative data for assessing any changes in the Advisory Council as a working group. This accumulation of bits of impressionistic and anecdotal information was eventually reviewed and sorted for use in determining whether or not growth occurred for the Council along nine dimensions of group growth. These were adapted from "Some Dimensions of Group Growth," which appeared in the Reading Book of the NTL Institute for Applied Behavioral Science, Revised 1970. The dimensions employed in this evaluation were:

1. intercommunication among members;
2. group objectivity toward its own functioning;
3. interdependence of responsibility by members;
4. group cohesion;
5. group ability to inform itself, think straight, and decide creatively about its own problems;
6. group ability to detect and control rhythms of group metabolism;
7. skill in recognizing and achieving control of socio-metric factors in its own structure;
8. integration of member ideologies, needs and goals; and
9. group ability to create new functions as necessary.

In order to assess the growth, change and achievement of the Advisory Council and its members from the perspective of the members themselves, each Council member was interviewed in the member's own work or home setting by one of four interviewers. An interview schedule was developed and pretested, and its final form consisted of a set-establishing introduction and 10 sections of stimulus questions. (See "Format for Interviews with Council Members" in Appendix B).

Several interviewer training sessions were conducted in order to introduce the interviewers to the scope and nature of information being sought. Interview sessions ranged from 1/2 hour to 2 1/2 hours. The interviews were a detailed attempt to understand the nature of the Advisory Council experience and learning over the year through the eyes of Council members. It was hoped that the interviews would expose feelings, thoughts, reactions, insights, and perspectives of the members that might otherwise remain buried and unavailable as data for evaluation and future planning.

Each interview was recorded live on audio tape. As part of the interview analysis training, each interviewer jointly listened to at least one of his interview tapes with one of the other three interviewers. Together they extracted all the bits of information from that interview and discussed the extraction process and format for recording, on paper, all of the extractions.

Each interviewer then proceeded to listen to the remainder of his own tapes and continued the process of extraction, calling upon other interviewers whenever consultation was needed. Each interviewer was then assigned the analysis and write-up of responses to specific questions, using all the bits of information from each question assigned. Joint review of all write-ups was conducted by four interviewers to assure that all significant information had been captured.

A final source of information to assess the extent to which the Advisory Council developed competency as a health planning group is the actions which were eventually taken in relation to recommendations on state health policy. Only one of the four project-related policy statements was published early enough for sufficient time to have elapsed for distribution and possible action for evaluation at this time. However, a partial list of actions resulting from Advisory Council policy statements is included in the findings, along with sample actions related to other Advisory Council recommendations.

The assumption is that a measure of the success of the work which produced policy statements is the resultant actions taken. The project staff viewed such actions as reinforcing the confidence of the Advisory Council in their ability to produce effective state health policy recommendations.

Findings

No attempt was made to submit the data presented below to tests of statistical significance because they were based on:

- information gathered for purposes of evaluation rather than research;
- information from a sample which was relatively small;
- instruments which were developed especially for this project and which did not possess preestablished validity or reliability; and
- instruments which were not administered under standardized conditions.

Instead, the analysis procedures used were of a simplistic nature and were aimed at presenting pictures of change in terms of direction and magnitude. Also, since the instruments were not intended to be of a highly sensitive nature, the significance of a change is determined more by the visible occurrence of a numerical shift than by statistical inference.

The Role of a Council Member

Twenty-three of 41 Council members returned both their November 1973 and May 1974, "Role of a Council Member" questionnaires. Table 1 presents their average scores on each administration and the direction and magnitude of each score change.

As indicated in Table 1, Advisory Council members strengthened their perceptions of the importance of seven functions, weakened their perceptions of the importance of three, and remained the same on five. Three of the items on which there was positive change may be thought of as "learning acquisition" functions (6, 9, 13) and appear to indicate that members strengthened their

Table 1

CHANGES IN COUNCIL MEMBER PERCEPTIONS OF THE
EXTENT TO WHICH CERTAIN FUNCTIONS WERE A
PART OF THEIR COUNCIL ROLE

<u>Functions</u>	<u>Mid Score</u>	<u>Post Score</u>	<u>Change</u>
1. Attend all Council meetings	4.3	4.2	-.1
2. Attend all task force meetings	4.2	4.0	-.2
3. Read mailed information prior to Council meetings	4.4	4.4	0
4. Speak up at meetings	4.2	4.2	0
5. Help others to speak up at Council meetings	3.9	3.7	-.2
6. Make sure that you always under- stand what's under discussion at Council meetings	4.2	4.5	+.3
7. Submit agenda items for Council meetings	3.4	3.8	+.4
8. Submit agenda items for task force meetings	3.9	4.0	+.1
9. Learn as much as you can about your task force's area	4.3	4.4	+.1
10. Get information for your task force	4.1	4.1	0
11. Write drafts of position papers	3.1	3.2	+.1
12. Offer resources of your own organi- zation or community group	3.5	3.8	+.3
13. Meeting with others outside Council to solicit opinion, reactions, ideas, etc.	4.0	4.2	+.2
14. Inform others about the work of the Council	4.2	4.2	0
15. Lobbying to support Council recom- mendations	3.0	3.0	0

Highest possible score = 5 Lowest possible score = 1 N = 23

perception of themselves as experiencing an educational process and taking individual responsibility for it. Four of the items on which positive change occurred (7, 8, 11, 12) appear to indicate an increased receptivity to "pitching in" and taking responsibility for Council work. The decrease in item 5 may represent an increase in feelings of responsibility for one's own participation while attributing the same responsibility to others for their participation. Since the Advisory Council began with many new members, this may also represent an increase in the effort and struggle of members to establish their own identity and source of influence as the year progressed.

The Socio-Emotional Climate of the Council

Twenty-three members of the Advisory Council returned both their November and May "Advisory Council Inventories." Table 2 presents their average scores on each dimension of socio-emotional climate, the direction and magnitude of each score change, and the lowest and highest scores at each administration of the inventory.

Table 2

CHANGES IN SOCIO-EMOTIONAL CLIMATE OF THE COUNCIL

<u>Dimensions of climate</u>	<u>Mid Score</u>	<u>Post Score</u>	<u>Change</u>
Genuineness	13.4	14.5	+1.1
Understanding	14.0	15.3	+1.3
Valuing	14.9	16.9	+2.0
Acceptance	16.9	17.3	+0.4

	<u>Mid Range of Scores</u>	<u>Post Range of Scores</u>
Genuineness	2 - 18	5 - 21
Understanding	7 - 20	11 - 20
Valuing	6 - 20	7 - 21
Acceptance	9 - 22	11 - 21

Highest possible score = 26 Lowest possible score = 0 N = 23

As indicated in Table 2, the Advisory Council as a group increased in each of the dimensions of socio-emotional climate. Another way of stating this is that the psychological health of the relationships between members was enhanced. It would seem to follow that, as genuineness, mutual understanding, and interpersonal valuing and acceptance grew, members were more able to truly be themselves and take risks to be assertive and creative in their work with each other.

It is noteworthy that the most increased characteristic was that of interpersonal valuing, i.e., respecting each other for the persons they are. This is usually a difficult characteristic to enhance in a large, task-oriented group. Another change of significance is that the lower limits of scores on each dimension were raised from the time of mid- to post-administration of the inventory. This means that persons who were initially hesitant about the extent to which others were being genuine, understanding, valuing, and accepting toward them reduced their level of hesitance and moved toward feelings of inclusion within the Council as a group.

The Socio-Emotional Climate of Task Forces

Twenty-two members of the Advisory Council returned both their mid and post Task Force Inventories. Table 3 presents their average scores on each dimension of socio-emotional climate, the direction and magnitude of each score change, and the lowest and highest scores at each administration of the inventory. All task forces were represented in the returned inventories, and, while the differences between task force climates is not represented, a general indication of climate across task forces is.

Table 3

CHANGES IN SOCIO-EMOTIONAL CLIMATE OF TASK FORCES

<u>Dimensions of climate</u>	<u>Mid Score</u>	<u>Post Score</u>	<u>Change</u>
Genuineness	14.9	15.8	+0.9
Understanding	15.5	16.7	+1.2
Valuing	16.8	17.6	+0.8
Acceptance	17.2	17.9	+0.7

	<u>Mid Range of Scores</u>	<u>Post Range of Scores</u>
Genuineness	7 - 21	7 - 23
Understanding	3 - 23	12 - 22
Valuing	10 - 24	11 - 23
Acceptance	11 - 24	11 - 23

Highest possible score = 26 Lowest possible score = 0 N = 22

As indicated in Table 3, the general climate in task forces was enhanced on each of the four dimensions. While the increase in scores was not as great as in the Advisory Council, this is understandable since the initial scores

were higher for the task forces than they were for the Council. The greatest change for task forces took place in the characteristic of mutual understanding. This change is reflected in the change in the range of scores for understanding, where a dramatic reduction in the number of low scores took place between the mid- and post-administration. While in November the lowest of the low scores across all dimensions was in the area of mutual understanding, in May that area had the highest of the low scores. It is possible that as task forces began to move ahead more intensely in their work on finalizing their recommendations, the need for understanding between task force members became more important and thus more actualized.

Attitudes and Perceptions of Council Members Regarding Council Meetings

A varying number of members completed and submitted the "How Did We Do?" and later the "How Did It Go Today?" meeting assessment questionnaires at the end of each meeting during the year. Three factors may have contributed in those instances when members did not respond: leaving meetings early, fatigue at end of lengthy meetings, and a general disenchantment with evaluations of this nature.

Table 4 presents the average scores of their responses to each question of the questionnaire for each Council meeting and, at the bottom of the column of average scores for each meeting, the grand average which depicts the general tenor of the response to each meeting. Presented at the right hand side of the Table is a grand average for each question, and this depicts the general tenor of the response to that question over all meetings. These are then ranked to indicate how positively Council members felt about each aspect of the meeting as compared to each other aspect. Finally, on the right hand side, for each question, is an average deviation which indicates the extent to which the responses to a question, over all the meetings, varied or stayed somewhat the same. The larger the number, the more variance there was. The ranking of these average deviations provides a picture of which aspects of the meetings were experienced by Council members in a similar rather than changing manner. The rank of 1 indicates the most similarity and a rank of 6 indicates the most variance. Questions (or aspects) 1 through 6 are treated separately from questions 7 through 11, since the latter five aspects were assessed over only the last four meetings.

Several findings seem clear from a review of scores on questions 1 through 6 in Table 4. Since scores for all aspects and general tenor of meetings were above the numerical midpoint (3.5) of the response scale, the reactions of the Council, as a group, to all aspects of all meetings were more positive than negative. The reaction to meetings that overall was most positive was the general reaction to the entirety of each session, even though this reaction was less stable and more changing (highest average deviation) than any other reaction. Question 1, then, appears to have tapped into strictly the affective component of Council members' attitudes toward meetings, and does not truly reflect a positiveness on all reactions, particularly those which are more cognitive in nature. The reaction which was second most positive was the long-range outlook which members held for the Council. It appears, then, that these two reactions were the most interdependent ones and that it can be reasonably assumed that how positive a member generally feels about a single Council meeting is influenced by the long-term prospects he holds for the Council and vice-versa. The two items which had the greatest stability, i.e., fluctuated least, over all meetings were the levels of clarity members possessed about the purpose of the Council and their own roles in it.

TABLE 4

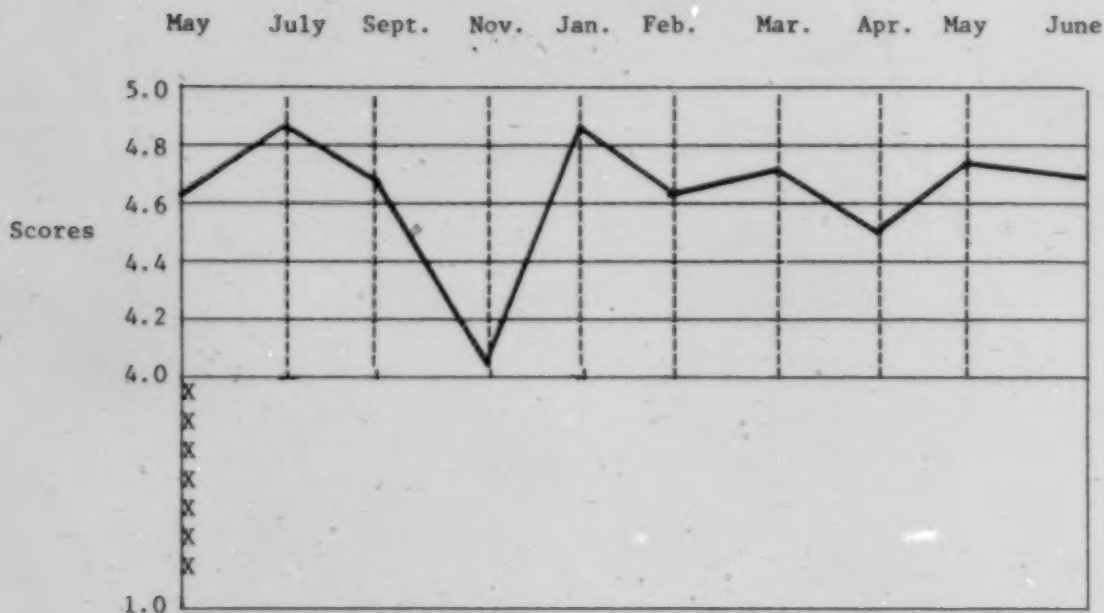
Council Members' Ratings Of Certain Aspects Of Each Council Meeting Throughout The Year

(Highest possible rating score = 6 Lowest possible rating score = 1)

Aspects of Council Meetings	(N=22) May	(N=19) July	(N=22) Sept.	(N=12) Nov.	(N=17) Jan.	(N=19) Feb.	(N=15) Mar.	(N=15) Apr.	(N=14) May	(N=16) June	Grand Average for all meetings	Rank of each Average of scores for all Average scores from the Devis.	Rank each Deviation of all each Aver.
1. How do you feel about our entire session today?	5.2	5.1	4.9	4.0	5.1	4.7	5.1	4.4	5.3	4.9	4.87	1	.302
2. How do you feel about your own participation?	4.0	4.6	4.4	3.9	4.5	4.4	3.8	3.6	4.0	4.0	4.12	6	.284
3. How much do you feel we accomplished today?	4.4	4.8	4.5	3.6	4.3	4.6	4.7	4.4	5.0	5.1	4.54	5	.300
4. How clear do you feel about the overall task of the council?	4.7	4.7	4.7	4.0	5.0	4.8	4.7	5.0	4.6	4.7	4.69	4	.156
5. How clear do you feel about your own role and responsibility in the work of this council?	4.6	4.8	4.9	4.2	5.0	4.7	5.0	5.0	4.9	5.1	4.82	3	.196
6. What prospects do you hold for this council?	5.0	5.1	4.7	4.5	5.3	4.6	5.1	4.7	4.7	4.9	4.86	2	.220
7. My feeling about being a part of the council today	-	-	-	-	-	-	4.8	4.2	4.9	4.7	4.65	4	.225
8. My feeling of investment in what we were doing	-	-	-	-	-	-	4.8	4.7	4.6	4.8	4.72	3	.075
9. My level of understanding of what was going on	-	-	-	-	-	-	4.8	4.8	4.9	4.9	4.85	2	.050
10. The extent to which members seemed to listen to each other-	-	-	-	-	-	-	5.3	4.9	5.0	4.7	4.97	1	.175
11. The influence I felt I had in the session	-	-	-	-	-	-	3.5	3.6	3.6	3.9	3.65	5	.125
GRAND AVERAGE SCORE FOR EACH MEETING	4.65	4.85	4.68	4.03	4.87	4.63	4.73	4.52	4.75	4.72			

The "general tenor" scores (grand average scores) for each meeting appear to take on more meaning when they are plotted as in Table 5. On examination, what appears to emerge is a sequence of alternate lower and higher reaction scores except for the November meeting. At that meeting small, minimally-structured, ad hoc discussion groups were used, contrary to the wishes of several Council members. This unfavored intervention was the Council's first experience with small groups during their regular, agenda-centered, task-oriented sessions. There were also two brief lectures on group process and planning process issues. These events apparently were incongruous enough with members' expectations to help place the meeting out of step with previous Council meetings. At the following meeting in January, two months later, the general reaction score jumped to its highest point. This jump functioned as a compensation, allowing the Council to return to its regular pattern and at its former level of functioning. The picture presented in Table 5 allows speculation that the Council developed its own alternating pattern in its meetings, but that this pattern was changeable by a non-normative intervention. While the intervention, in this case, lowered member reaction, it seems reasonable to assume that other non-normative interventions might heighten member reaction.

Table 5
MEETINGS



Profile of general reaction scores of Council members for each Council meeting.

Regarding questions 7 through 11 in Table 4, it can be observed that listening and understanding were perceived as being in existence more than the other

three aspects. Feeling of personal influence was markedly lowest. Level of understanding fluctuated least across meetings and the goodness of feeling about being a member of the Council fluctuated most.

Observations of Advisory Council Meetings

The observations made at each Advisory Council meeting by the educational consultant and recorded as a log of observations were extensive and varied, as were Council members' responses to the open-ended question on the evaluation questionnaire administered at each meeting. Presenting this information in a meeting-to-meeting format seems unnecessary here. Instead, to provide some manageable and meaningful imagery of the growth and change which appeared to occur within the Advisory Council as a group, a picture of the Council's meeting in May 1973, just prior to the beginning of the educational and development project, and another picture of the Council's meeting one year later in May 1974, are now detailed from the perspective of the educational consultant. In addition, observations of the growth of the Council as a group are presented.

The Advisory Council Meeting of May 9, 1973:

It is 1:30 p.m. and people are walking into an overly large, high-ceiling room. Most are hesitant, walking alone, half-looking around, their eyes mostly straight ahead, carrying a slight smile, providing "pardon me's" when uncomfortably brushing up against another person, and searching for their name plates which are at places pre-established by staff. A few, apparently "old-timers," are privately chatting and handshaking, and in an accustomed, business-like manner find their name plates and seat themselves and look to the chairman to call the meeting to order. The members are all sitting outside of a large hollow rectangle comprised of long tables.

The chairman formally calls the meeting to order, everyone quiets down, and the business of moving through an unquestioned agenda proceeds. Verbal participation is carried by a same few persons, who raise their hands to be recognized. "Mr. Chairman," "Doctor," "Dean," "Mr." and "Mrs." are used when one member refers to another. Reference is never direct, but always in the third person. Many persons have momentary facial expressions which show uncertainty and non-understanding but these expressions seem to disappear quickly as though they might be perceived as risk taking disclosures of ignorance. There is a short coffee break around 2:45 p.m. without much mixing and the meeting resumes with people already at their places.

A guest is called upon for a brief presentation, but the presentation continues on at length without interruption, although fidgeting, squirming, and helpless appearing across-the-room looks are exchanged. A few heads shake side to side with the nonverbal message of "I can't keep up with it all." The presentation is over and the same members as before raise questions and give reactions. The comments of the main contributors seem to have an overlying message expressing their being part of an in-group. Certain phrases, words, and pieces of humor have special meanings to a few, and letter combinations are used heavily as shorthand titles of organizations and agencies. When the letter combinations are used, brief quizzical looks of despair appear on many faces. The conversation is being carried on mainly by provider members; they look tall in their chairs; consumers actually look smaller. Some oblique, semi-facetious comments are made about people who are smoking.

The agenda continues on and by 4:00 p.m. several members appear weary and disinterested. At 4:30 p.m., the chairman asks for a motion for adjournment and most persons hurry off after completing a post-meeting evaluation form.

Comments which members write on their evaluation forms deal largely with the meeting's content, size of the agenda, need for more pre-meeting information, need for more coffee breaks, and need for more time to meet in order to accomplish the task.

The Advisory Council Meeting of May 16, 1974:

It is 9:15 a.m., and people are leisurely picking up their folders and name plates outside the meeting room. Everyone is either standing around or sitting in small clusters drinking coffee, checking notes, exploring each other's positions on issues, or reviewing plans for a presentation at the meeting. As 9:30 a.m. approaches, most people begin to self-select a seat at a solid square table made up of many smaller tables. There is minimum room between chairs and the people appear to be in close social contact around the table. The room has a low ceiling for its size, is many-windowed, and has a sense of warmth and freedom of movement.

Although it is 9:30 a.m., time to start the meeting, some small clusters of members are still in conversation at the main table or in spots around the room. The chairman calls attention to the time, and all Council members present take a seat at the table. The beginning of the total group session is more like a transition from a period of subgroup conversations to a large group conversation, rather than a formalized start-up. A secretary calls the roll and as the names of some persons who are not present are called, the chairman mentions why they could not be present today. The chairman reviews the suggested agenda for the day and asks the group if they wish to suggest any alternatives or additions, or if there are any clarifications needed. After an acceptance by the group of the agenda and the minutes of the prior meeting, the chairman reviews the members' evaluation of and reactions to the prior meeting and mentions procedural actions which have been taken as a result of members' suggestions. There is some discussion around the evaluation results of the prior meeting and some further suggestions for enhancing the group's operation.

The group begins to move through the agenda and there is much spontaneity and interaction around reports and issues as members carry responsibility for initiating presentations, asking for clarification when statements seem unclear, requesting information and perspectives from each other, providing support and encouragement after a member's contribution, keeping a question in focus for the group by summarizing discussion and restating the question, directly confronting another member's difference in opinion, and slowing down the decision-making on an issue when implications of "railroading" emerge. References to members are mostly but not entirely by first name. There is very little third person reference and most often members are addressed directly by each other. Members get up and replenish their neighbor's coffee as well as their own.

A momentary sense of family feeling occurs when a male provider member kisses a female consumer member on the cheek as she leans over to bid him hello after entering the meeting late.

At 11:45 a.m., the meeting is adjourned and members move to another room of small tables for lunch. Some task forces or committees use lunch for meeting time.

The meeting resumes at 1:15 p.m. and continues with an open sharing of philosophical and practical disagreements, situational humor, and messages of affection through voice tone and name use. There are, at the same time, some facial and vocal expressions of tension over unresolved personal disagreements. Some signs of fatigue from efforts at trying to be understood on specific points also appear through headshaking and despairing looks.

The meeting ends at 3:30 p.m. with the emergence of a general agreement that it's time to quit, with some items to be held over until the next meeting or referred to the Executive Committee for handling. Members who are willing, complete and submit their post-meeting evaluation forms. Some members linger on over a final cup of cool coffee, rehashing actions taken by the Council or setting dates for subgroup meetings prior to the next Council meeting.

The post-meeting evaluation forms contain fewer responses to the open-ended question, since members shared most of their comments and suggestions openly during the meeting. One comment which appears similarly on several forms is feedback about one Council member on a commonly perceived obstructing behavior. Norms and comfort have not yet been established for open sharing of this kind of personal information within the group setting.

Observations on the Growth of the Council as a Group

Over the year it was possible for the complexion and dynamics of the Council meetings to become more negative, stay relatively the same, or become more positive. To the extent that the observations are accurate, the experiences at the meetings became more positive. Observations at all meetings of the Council and Executive Committee during the year reflected growth of the Council as a group on several dimensions.

- Intercommunication among members improved and was reflected in semantic sensitivity, commonality of vocabulary, relaxed but well understood rules of procedure, and permissive expression of needs, concerns, ideas, and fears.
- Group objectivity toward its own functioning was enhanced as members made and accepted interpretations about member and group functioning, and collected and used information about themselves.
- Interdependence of responsibility by members showed gains as members shared leadership functions of direction setting, clarifying, summarizing, harmonizing, encouraging, etc.; made adjustments to other members and the chairman at various stages; achieved some mutual sensitivity to needs and styles of participation of each other; and initiated subgroup work on the basis of diagnosed need.
- Group cohesion grew as demonstrated by the Council's assimilation of new ideas without group disintegration; assimilation of new members in ways to strengthen rather than disrupt the group; holding long-range goals in perspective when faced with pressures for short-term decision and action; profiting from success experiences and learning from failure experiences; and making constructive use of some internal conflicts.

- Group ability to inform itself and to think straight and decide creatively about its problems increased as the Council used the contribution potential of many of its members: providers and consumers, men and women, and newer members and older members.
- Group ability to detect and control rhythms of group metabolism was enriched as the Council members became more sensitive and responsive to fatigue, tension, tempo, pace, and emotional atmosphere.
- Skill in recognizing and achieving control of significant sociometric factors in its own structure was developed as some Council members took responsibility for encouraging and attracting some peripheral persons toward more participation and gave feedback to some overly assertive persons to reduce their influence.
- Integration of member ideologies, needs and goals was furthered through the deliberate provision of time and patience to work through differences in positions on issues by extended discussion, confrontations, calling upon members and outside resources to represent value differences, and the readiness to include minority reports.
- Group ability to create new functions as necessary grew as evidenced in the Council's creation of a new subgroup in response to a member's persistence and perception of need; revisions of Council and task force meeting times; conducting of a workshop for members; and delegation of emergent responsibilities to Executive Committee and ad hoc committees.

All this is by no means to say that the Council reached or came close to reaching its potential in functioning as a group. This is to say that it changed positively on each of the above-mentioned nine dimensions of group growth.

Much challenge still faces the Council if it is to increase the collaborative use of all its members' intellectual and experiential resources, become more creative in its problem solving processes, and experiment more with methods and practices which are oriented toward open inquiry.

Interviews of Advisory Council Members: The Nature of the Council Experience

Each of the 39 Advisory Council members were interviewed at the end of the project year. Two members were not. One had died during the year and the other was out of the country during the interview period. The 39 shared their own perspectives of the experience of being Council members through conversational responses to stimulus questions and further probes under 10 areas of inquiry in individually conducted interviews.

While the information presented here is lengthy, the many quotes have been included to preserve its specificity. The quotes were extracted and condensed from more extensive information on 39 audio tapes. What follows for each of the 10 areas of inquiry is the set of questions, a statement as to how the responses are organized for that set, and then the responses. Information which did not fit the 10 areas of inquiry is then presented.

Question 1.

How do you see yourself operating in the Council? As an individual representing yourself, as an individual representing a group, or as an advocate of a very particular issue? (If either of the latter two) Which group or issue? What is the size of the group?

The information under this question is organized by first presenting the categories of representation members perceived themselves as bringing to the Council and the number of each. Further specification and clarification of the responses under the three major categories is then given. This provides some idea of what members were speaking for and for whom they were speaking when they expressed themselves.

<u>Categories of Representation</u>	<u>Number of Responses</u>
As an individual representing self	5
As an individual representing a group	16
As an advocate of a particular issue	1
Both as an individual representing self and representing a group (1. and 2.)	9
Both as an individual representing a group and an advocate of a particular issue	3
As all three--an individual representing self, an individual representing a group and an advocate of a particular issue	5
Total Responses	<u>39</u>

As an individual representing self:

Council members who indicated they were individuals representing themselves, seemed to define this role in two subtlety different ways. One of these definitions seemed to reflect operating in a way which was completely distinct from any relation to others or groups. As one member said,

"At least one-third to one-half of my participation has no relation to any group I'm representing, but I'm functioning as an individual."

Another slightly different perception of the role seemed to reflect an awareness of the individual as part of a whole, or as viewing a whole.

(I operate) "as an individual working with all the people together on the whole."

"I'm operating more as an individual as I perceive the total health scene."

In trying to clarify their particular mode of operation, several members indicated that it was difficult to separate the role of individual from the other roles they might assume.

"I represent a group, but I also represent my own viewpoint. I can't avoid that."

Members who spoke or acted as individuals drew upon several kinds of resources. Some of the responses indicated the utilization of inner resources, such as confidence in their own opinions, or creativity.

"I have personal opinions I don't hesitate to get out."

"I occasionally have an individual, creative idea."

Other members indicate that they drew on the resources of their personal and professional experience:

"I'm trying to look at it as an individual who knows, over years of experience, what the people need."

"I don't see myself as representing any particular constituency. There is one area of expertise that I bring to the Council. . . in health manpower as it relates to the albeit-health field."

One respondent mentioned utilizing the external resource of research:

"I speak on what I believe, not from a selfish view, because I don't make a statement that will have impact, unless I've done research on it, and usually pretty thoroughly."

There seemed to be some indication that respondents who felt they operated as "individuals" equated this method of operating with objectivity, while people operating as "representatives" or "advocates" might tend to be more narrow in their viewpoints. One member felt that it was important for people "to put aside any narrow considerations of interest groups". The following two quotations reflect the connection of the individual role with the positive concept of "pure objectivity":

"I try to operate as an objective board member with no vested interests."

"I see myself on the Council as one of the very few people there who can operate hopefully abstractly without feeling any particular ties to any particular group. . . I realize that to some extent, this can be a fanciful delusion because we are all polluted to some extent by our background and needs."

As an individual representing a group:

Of those responses in which a member indicated that he or she was an individual representing a group, the following kinds of groups were mentioned as being represented:

<u>Kinds of Groups Represented on Council</u>	<u>Number of Responses</u>
State and local health organizations	7
Physicians, dentists, nurses, hospitals	9
Consumers, citizens, the public	14
Educational institutions	3
Minorities	3
Total Responses	<u>36</u>

It should be noted that Council members who were members of any of the above groups did not always state that they represented those groups. Therefore, one cannot assume that Council members fitting the above descriptions necessarily felt they represented that corresponding organization. For example, 14 Council members responded that the group or groups they represented were mainly consumer groups. Of that 14, 5 respondents were provider members of the Council and 9 were consumers.

In order to indicate the size and nature of the groups represented on the Council, samples of quotations follow, organized under a heading for each of the five kinds of groups mentioned.

State and Local Health Organizations

"I represent my entire organization. . .10,000 to 12,000 employees."

". . .a statewide department of 14,000 employees and in local public health, another approximately 14,000."

"All the people in the health service area."

Physicians, Dentists, Nurses, and Hospitals

"I represent physicians as a group, statewide and pretty much nationwide. . .over 10,000 physicians in the state and over 300,000 in the United States."

". . .represent nursing-at-large."

"I do think of myself as sometimes carrying their flag. . . ."
(the physicians)

Consumers

"I clearly represent the statewide consumer-users of medical services."

"At times, I represent the total nine million consumers of this state."

"I really represent about 75 percent of the homemakers--the middle, low-middle class and the working poor, except the two extremes of extreme poverty and extreme wealth."

"I vote along the lines that seem to be best for the community-at-large."

One Council member pointed out that it was often difficult to distinguish between times when one is representing his organization and he is representing the consumer:

"It's hard to distinguish between issues which represent our department and those which represent the public. They're not easily divisible, so I try to represent the public, too."

Educational Institutions

"Sometimes I represent education, as a group, especially when implementation or structure needs to be considered."

"My comments are keyed to what the impact would be on health education and research in a university setting. . .not of any particular university, but as a medical health education representative of physicians and university throughout the country."

Minorities

"I see myself as representing the City of Detroit, and specifically, the black population, and, in general, the minority and poor population."

". . .the blind, the Indian and the poor. . . ."

One member who stated representation of minorities felt that the Council was "loaded with education people" and that there were few minority members, so, it was important to represent them on the Council.

As an advocate of a particular issue:

A few members saw themselves as advocates of a particular issue and some of their comments were:

"I see myself as an agent of state government really looking at the whole continuum of health planning as it has emerged since 1968."

"An advocate of better, more accessible, more rational health care for the state."

"I am an advocate of local level health planning."

"In this hat, I handle and reflect health legislation and how it represents national viewpoints."

"I felt a duty to advocate issues for the poor."

"I am an advocate of issues helping minorities."

Other advocacy issues mentioned were. . ."abortion". . ."issues affecting the people". . .and "women's rights."

Question 2.

Were you a consumer or provider member of the Council?
Did this have any implications for the way you participated on the Council? (If clarification is needed)
Did this influence or affect what you said and did as a Council member?

The information under this question is organized in two parts--first, regarding type of membership held; and then, the implications of this for participation.

<u>Type of Membership</u>	<u>Number of Responses</u>
Consumer	18
Provider	16
Both	3
Neither	2
Total Responses	<u>39</u>

The majority of Council members responded that they would define their membership as corresponding to the consumer or provider position to which they were initially appointed on the Council. Three members, however, felt that, despite their "official positions," indeed they were really acting as both. For example, as one member said, "Although I am a provider, I see myself many times as a consumer." Two members felt that they were neither a consumer nor a provider. One said, "I don't see myself as a consumer in a medical system, as such. I really see myself as a taxpayer." The other respondent said, "Neither category fits so well." This member saw himself as representing an administrative, budgeting, coordination function that serves both consumers and providers.

<u>Implications for Participants</u>	<u>Number of Responses</u>
Did have noticeable implications	24
Did not have any noticeable implications	15
Total Responses	<u>39</u>

Respondents noted that being either a consumer or a provider affected their participation on the Council in different ways. Six are cited below.

Effects on members' feelings of preparedness.

Members noted that being a consumer or a provider was a natural consequence of the kinds of previous experience they had had. Therefore, the designation

"consumer" or "provider" was directly connected to the experience and amount of preparation members felt they initially brought to the Council. As one provider said, "Yes, how could it be otherwise?" This member felt that one's professional background and past experience all influenced reactions to other members on the Council, as well as the work that was done there. Several providers mentioned feeling well-equipped to function as members, by virtue of their experience. One said,

"As a provider I really found myself way ahead of the game."

This provider also mentioned, by contrast, that consumers needed more help than providers.

Many consumers indicated that they did not feel initially prepared to participate in the Council. Some of their comments were:

"At first, yes; I felt inadequate because of lack of expertise."

"Consumers are overpowered by knowledge. I was told by one of the Council members, 'You'll never be able to understand what is going on here, so the best thing you can do is vote with the doctors.'"

"It's very, very difficult for the consumer to really contribute. Time doesn't permit you to research some of these things that a person from a service organization who works full time and has access to research can do."

Some consumers indicated that this lack of experience not only made it difficult to actively participate, it also made it difficult to listen. One member said it was difficult to keep up with the medical "jargon." Another said,

"From the comments of other consumers, it seemed difficult for them to follow."

Another member mentioned the ease with which providers tossed around the names of organizations by their initials, while consumers often did not have any ideas of the meaning of these abbreviations. This respondent felt that the new glossary of organization names and abbreviations provided by staff during the year was helpful, however.

Effects on specific experiences of members.

One provider felt that he was sure that being in his role had an effect. This member felt that it is natural to be biased toward specific issues and people with whom you have some particular professional concern. Other providers said:

"The role prejudices my point of view."

"Professional relations orient one in certain ways."

Consumer respondents likewise felt that this role influenced their interests on particular issues. One stated that while they tried to understand the medical point of view, they also tried to "slant it from the viewpoint

of the consumer." Another felt that a special interest in particular kinds of consumers such as minorities, had influenced their levels of concentration and emphasis of participation on the Council.

Consumers also indicated that their perception of their Council role influenced the point of view they emphasized.

"I am a consumer so I presume that when I'm speaking, I am thinking of the consumer side, perhaps more than I am for the prover's side."

Another consumer saw their role as "serving as a generalist in terms of the state," but did not feel that the role of consumer had other than a minimal effect on participation.

Effects on expectations others had for members.

Respondents indicated that their roles affected the expectations they perceived others had for them. One consumer felt that his actions on the Council may have seemed to some very "naive," as this consumer asked questions about sources of money or the function of the Council. One member mentioned feeling defensive as a provider, due to negative public relations about the role of medical helper to the consumer. Another provider echoed a similar feeling,

"I feel there are people (on the Council) who are skeptical of providers and what they have to say. They feel they're self-seeking and self-interested. I'd honestly say that the providers I've talked to are not self-seeking or self-interested. They're trying to do a job for the public."

Effects on specific member goals and how they are implemented.

One provider stated that his participation was affected in that it affected his specific goals.

"Yes, it defined my place as representing the industry. I try to bring to the attention of the other Council members how their decisions will have impact upon the industry."

Other providers said,

"Sure, I act as a health professional all the time. Almost every comment I make is made with the question, 'What will be the impact on the health profession?' I don't attempt to speak as a consumer or a representative of the public."

"I'm concerned with keeping it practical since some on the Council have no practical knowledge as to how things can be implemented through statute, and so on."

"As a provider, I have spent more time educating lay people on the various aspects of health planning."

One consumer indicated a growing awareness of the role of consumer as one whose "expertise" as the community.

"As the year went on, I was able to influence my own community by the information gained from the Council and able to influence the Council from my community experience."

Effects on kinds of things members discussed.

Several respondents said that their roles influenced the kinds of things that they talked about. They felt that consumers were seen as spending more time discussing consumer medical costs while providers spent more time on medical facts, systems, and an overview of the medical picture.

One provider pointed out the kind of content providers might typically introject at meetings,

"You can't do without interested and concerned providers to give input on quality health care, accessibility and reasonable cost."

One provider explained the difference between the content of consumer and provider concerns in this way:

"A good example is that the cost of running hospitals differs from the cost of being hospitalized, and my number one responsibility is to affect a more efficient manner for the industry to go about business."

A consumer explained the difference in these terms:

"I have more to say when they're talking about costs to individuals than I would when they talk about facts and figures...it's sort of overwhelming for someone who hasn't had a part before. You come away with your head swimming."

Another consumer notes the same distinction and the lack of expertise which consumers may feel.

"You can get any one of the consumers to day, "The prices are too high but you have no basis in fact for it...it's like a volunteer Sunday school teacher talking between a Professor of Education at the University of Michigan and a History Professor at Purdue and this poor volunteer...it will be a bit of a time before she can get between them. They, at least, have some common bond."

Effects on amount of talking by members.

One consumer said,

"Most of us have sat back and let providers form many of the big plans. I've given my ideas, but I've taken a back seat to the professionals because I feel they've so much more to offer when it comes to actual planning..."

A provider stated,

"I think it would be very hard to be a consumer on the Council. There isn't any question about it. Most of the talking is done by the providers. They're the most conversant in it."

One consumer seemed to indicate that the role was a "freeing" one,

"I feel I can free-wheel better than a provider. I think I would be somewhat subjective if I were a provider."

No noticeable effect.

Respondents who indicated that the designation of consumer or provider did not influence their Council participation in any noticeable way, explained this with different reasons. Several indicated that the lack of any effect upon their participation was due in some way to their own objectivity or independence.

"Being a provider did not influence my behavior on the Council. I tried to be objective."

"I'm individualistic. I will say what I believe. If I were a provider, I wouldn't act much differently."

"No. I am a pretty independent person."

Other members stated that their responses were in some way related to not taking sides with either consumers or providers.

"If I think in terms of my being a representative of organized medicine, I'm afraid not...I can't be considered a consumer but...I often take positions against organized medicine and for the public, so the content is often more akin to the consumer's position. If we get criticized from both the consumer and the provider...we can't be all wrong!"

Others seemed to equate their participation not being affected with the personal freedom they felt to speak at the Council meetings.

"Not really. A lot of other consumers don't speak up, though. The meeting is dominated by providers. I felt free to speak up as a consumer. I'm a political animal."

"I expressed what I thought and what I believed." (this member felt he, as a provider, represented the consumer's viewpoint often)

Another consumer member felt that being a consumer did not influence his participation, but did feel that most of the consumers felt overshadowed by the providers on the Council, but not in the task force. Another member felt that being a provider did not influence what this member said or did. However, he felt that the real influence was the personal experience this member brought to the Council.

Question 3.

During the year you were faced with a great deal of information in both written and orally presented form about health, health systems and health planning. There may have been information that confirmed or reinforced things you already knew, information that corrected what you felt you previously thought was true, information that somehow gave you a new perspective on things, or information that was brand new to you. Please tell me what you recall under these areas. Rank the four areas as to how much each occurred for you.

The information from this question is presented by reporting first, the number of responses indicating the amount of each type of learning, and second, learnings recalled by members.

The majority of respondents chose only one type of major learning rather than ranking all four. The number of choices for each type, or area, follow.

<u>Types of Learning</u>	<u>Number of Responses</u>
Information that confirmed or reinforced	20
Information that corrected	7
Information that gave new perspective	5
Information that was brand new	0
Total Responses	<u>32</u>

Some Council members reported they had difficulty recalling the particular information they had received during the year. They expressed concern that there was too much information given them. Two expressed the view that the information given was not read completely. One of the two stated: "I never read any of it--except in task force." The other stated: "Probably only one-fourth of the people have read information in any way; about one-half have skimmed it only." One provider stated that he found it difficult to classify information, because he had been in the field so long and it was hard to distinguish one kind of information from another.

Council members found the experience of recalling information easier by expressing broad subject areas. The learnings recalled by members seem to have three major sources: learnings from topic areas presented orally and on paper from task force reports and special issue reports; learnings related to the experience of participating as a member of the Council; and learnings related to the health planning process.

Learnings received from task force reports and special issue reports.

These learnings comprised the area with the largest recall. Some Council members stated that they increased their knowledge of maternal and child health. For example, individuals became aware of nutritional needs and factors, the facilities available for high risk mothers and children, and statistics related to the infant mortality rate. One Council member stated that the position taken by some insurance companies, not to insure the first two weeks of life, was a brand new piece of information and very shocking. A number of respondents recalled information about Medicaid. One member recalled statistics of where Medicaid money was going. A provider stated that he learned that a small percentage of the recipients in the Medicaid Program are responsible for a large percentage of the expenditures. Other members reported learnings about health maintenance organizations. One individual stated that he questioned a "for-profit" HMO and he had assumed such an organization should not be encouraged. He discovered there was no information to support this contention so he altered his view. A number of Council members recalled learnings about cost containment in hospitals. One respondent reported that the certificate of need exercise gave him a new perspective on problems facing hospital administrators and on maintaining financial viability in a system that is 100 percent constraining. Other areas of learnings received from task force reports and Council discussions were about minority group inequities, understanding of medical terms, the renal program, and health statistics.

Learnings related to the experience of participating as a Council member.

One learning recalled was that to develop and decide upon a statewide health plan that meets the needs of a variety of people from different geographic areas, a Council member needs the divergent viewpoints and experiences of other members who are from different experiences and areas. Some Council members reported that they had observed and had a better understanding of the difficulty of consumers to speak up as easily as providers. One member stated that there was one written comment at the end of a meeting suggesting that doctors not talk so much and this gave him a new perspective. He said:

"I think people should express their views, it may hurt a little, but it's a little different being told by your colleagues than by someone else; it made me realize that other people did have something to say . . . I've begun to understand others' needs and views."

Learnings related to the Health Planning Process.

Members reported having an increased awareness and understanding of the political process as it relates to health planning. One respondent stated that he now had some awareness of the workings of state government such as the relationships between different state departments. He stated that he was not previously aware of these relationships until he needed to think about the political implications of the health objectives he was trying to achieve. Other Council members reported they learned to approach broad, complex health problems in a more intelligent manner through the use of the steps of the health planning process.

One individual reported the following learning:

"Where health care facilities are located in the state; it broadened my perspective of what is available in the state, where it is; how it works, how good it is and how it interrelates, and how the patient flow comes and goes.... This has helped to formulate my thoughts about health planning."

A large number of Council members felt they were given too much information to read and to be expected to synthesize. As volunteers, some members felt that, due to time, the expectation that they read so much material was unrealistic. Some members suggested that a summarization or synthesis of information that was sent out or presented orally would be helpful. There appeared to be a feeling among Council members that they were appreciative of all the information given to them and that they had received much which could not be assessed during a short interview session.

Question 4.

Do you recall having received information about the steps of the health planning process? To what extent did your task force actually use these steps in its work? To what extent were these steps helpful in the work of the task force? (A list of steps in the health planning process was handed to the Council members)

The information under this question is reported by discussing responses to each of the three subquestions.

Do you recall having received information about these steps of the health planning process?

Thirty-one Council members responded that they did recall receiving the steps. A number of respondents were a little unsure as to when and where they received the steps. Some members recalled having received the steps through the following experiences: oral discussion of the Executive Committee, Task Force Guidelines, handed out in written form from OHMA as a preliminary to task force work; introduction of steps during a fall Council meeting, and during orientation to the Council. One Council member was unsure if he had received the steps, but remembered talking about the process. A recently appointed Council member stated that he did not recall receiving the steps.

To what extent did your task force actually use these steps in its work?

Twenty-two members reported that their task force had used the steps to a noticeable extent. Some of these individuals were consciously aware of the time of their use by the task force. Some members realized that they had used these steps only after discussing what their task force did during the year. Comments ranged from: "Did, but we did it all without knowing it" to "Used every step and probably added three or four to it." Five Council members reported that their task force used the steps to some extent, and

three of these members mentioned two or three steps that they felt the task force did not use. Some respondents could identify a number of steps which were carried through, but stated that they were aware of a general process going on, not necessarily the specific steps. Three Council members perceived their task force as using the steps to a little extent. These members inferred that these steps were used "minimally." Two Council members stated that the task force did not use the steps at all, indicating that the staff used these steps, but not the task force members. Five Council members did not respond to this question, because of their lack of attendance at task force meetings.

To what extent were these steps helpful in the work of the Task Force?

Twenty-two individuals considered the steps helpful to a considerable extent. The following comment summarizes many of the reasons expressed for the steps being helpful:

"Steps very helpful. Every once in awhile someone would want to get into fine print and we would remind ourselves of our purpose--to give broad recommendations first. These quite definitely kept us on the right track. We reviewed steps when we got away from the subject--not that we had these specific steps we referred to--but the process kept being brought up avoiding getting hung up on little points."

One Council member responded that the steps were helpful to some extent. One individual stated: "Chairperson could respond best in assessing this. I'm not sure this chairperson was aware of what we're doing in whole planning process. . . a moderate degree of value--things working out pretty well on task force." Five Council members considered the steps to be helpful to a little extent. Two types of comments appeared here. One feeling was doubt that the use of the steps made much of a difference in the work of the task force. The other kind of response was that the steps could not be considered very helpful, because they were not used to any extent. One Council member felt that the steps were not helpful, and stated: "These steps were not helpful to me, because the underlying explanations were not adequate for the consumers to put together." No specific answer to this subquestion was obtained from six Council members.

In general, the majority of Council members recalled receiving the steps of the health planning process although they were unsure as to where or when they received the steps. The majority of members felt the steps were used by the task force and they found the steps helpful in directing them toward effectively reaching the goal of their task force.

Question 5.

I would like to find out how you experienced the many different people on the Council. At the first couple of meetings you attended, how many members did you know, how did you feel toward them, how did you feel toward the others you did not know? Did any of this change

for you over the year? (If yes, ask person to state what changed). What occurred that helped bring about this change?

The information under this question is presented in narrative form following the sequence of the subquestions above.

At the beginning of the year, 11 of the consumers knew one to 10 of the other members on the Council, five did not know anyone else, and five knew over 20 other members.

Those respondents reporting that they knew one to 10 other members were all new to the Council and several were new to the health field in general. They reported that people were very friendly to them; they were not bothered by the fact that they did not know many people or that they had no particular feelings toward other individuals. Some of them reported anticipation of meeting new people and stated they were unaware that there were provider and consumer members, but became aware of this difference in background as other members expressed their opinions on various issues. Their respect for people grew as they listened to the discussions and their confidence in their own abilities grew as they participated in the discussions. There was some degree of awe of the professionally titled members and as they became aware of those who had extensive experience in the health field some degree of deference to their opinions developed. They said that there were certain members they could trust, believe, or depend on more than other members. These members also remarked that they were generally impressed with the caliber of people on the Council.

They were very aware that the Chairman and the staff made special efforts to include them in discussions; sought them out during coffee breaks, solicited their opinions and encouraged them to speak up in sessions. Only one respondent did not see the leadership as helpful to consumers, and perceived these efforts as patronizing. There were some feelings that there really wasn't a constructive role for consumers as they weren't experienced enough. However, it was strongly felt that consumers should play a role on the Council. There were also some feelings that at times the leadership took the consumers' frustrations as a joke; such remarks as "Do you consumers understand?" were annoying and gave rise to feelings of non-inclusion. A few consumers perceived the Council as a very formal group with providers monopolizing the knowledge.

Consumers reporting that they knew 10 or more people had mainly been on last year's Council, and had professional contacts with some of the members of the Council. They expressed a special awareness about the level of knowledge, skills and experience that the providers brought to the Council and they felt that some of the providers were often representing special interests rather than themselves. They felt this way especially toward medical school personnel and insurance personnel. They felt that some providers unduly influenced the Council through their control of knowledge and identified providers as an elitist group. Some felt that there was some carry-over of close contacts between providers from previous Councils and that consumers had a small role to play in the Council as they lacked political sophistication. Several identified members from state agencies

as being protective against Council recommendations because of past experiences in which their agencies had suffered.

None of the providers reported not knowing anyone at the beginning. Six knew one to 10 persons, eight knew 11 to 20 people, and six knew more than 20. Several providers knew each other from professional contacts, and were acquaintances of long-standing. Some knew other members from previous Councils, and some knew others through correspondence or by reputation. Providers stated that they were respectful of each other's expertise, and reported good personal relationships even when differing in philosophy, values and interest. The majority of providers perceived the consumers as being reluctant to speak up because of inexperience and some said they tried to encourage them to do so. Several expressed the need for more education for consumers in order for them to be more active in the planning process.

One provider member felt that consumer influence should be the strongest on the Council and therefore felt defensive because of his own assertiveness in meetings. He said that initially he found himself editing his contributions so as not to be viewed as overly demanding or unfair. His defensiveness decreased as he got to know more members and felt their acceptance, understanding, and attention.

Both consumers and providers felt that change toward people occurred as they sat next to each other in Council meetings or at lunch, talking at coffee breaks, and working on task forces together. Working on task forces was mentioned more frequently than anything else as an experience which induced more positive attitudes. Three persons reported that the evening workshop was helpful in getting to know people. Several of the people from the previous Council mentioned the helpfulness of the retreat in this regard. Others mentioned the use of name plates on the tables, staying overnight, having extra meetings and the intimate setting of the University Club as being helpful in getting to know people. Several felt that it was mainly through their own, purposeful efforts that they got to know people. One person did not feel it was necessary to get to know people in order to accomplish a task and related this to his negative feelings about the smiling faces on the meeting assessment questionnaire. This respondent said:

"Everyone says that it is a good thing: I don't know why. Smiling faces seem to make it implicit that you are to be a part of a fellowship group as well as a member of the Advisory Council. I don't know why. It may be true...I find such tasks aggravating...don't like answering questionnaires to begin with."

Despite these feelings, he also said that he had experienced groups where such tools helped people be more open in discussions.

Two members said they were uneasy with the questionnaire in which they were to express their feelings about others and one did not return it.

Several members, both consumers and providers, reported that as they worked together they developed negative feelings toward providers they perceived as "soap boxing" and pushing a special interest almost to the exclusion of others. Some providers expressed negative feelings toward people who were brought in to give them "the word." One person questioned the number of doctors and medical school personnel on the Council and felt that more nurses and other health type people would have presented a more balanced group.

Question 6.

I would like to find out how you experienced the Council. What was it like during the first couple of meetings you came to--regarding such things as the way the Council made decisions, the atmosphere or climate, ability to work together as a group, sense of involvement, etc? Did any of this change over the year? (If yes, ask person to state what things changed). What occurred that helped bring about these changes?

There was no identifiable division between responses from consumers and providers as they experienced the Council as a group. The data is presented under four headings: atmosphere, ability to make decisions, ability to work together and sense of involvement.

Atmosphere

The majority felt the atmosphere was very friendly, warm and open; people were listening to each other with lots of discussion and no sense of behind-door decisions by a select few; opinions were respected by others; a positive atmosphere existed, especially for providers, maybe less so for consumers. There was some frustration expressed over so much work to do and not enough time to pursue philosophical discussions. The majority felt the Council was provider-oriented, especially in the beginning. As consumers became more knowledgeable they entered into the discussion more but did not really influence the Council. Many felt that the chairperson created a good atmosphere by his attitude and behavior. Two respondents felt there was less acceptance by the OHMA staff head and that there was some strain between the Council, OHMA and the chairman of the Council. There was a feeling by some that the atmosphere very much depended on the issues being discussed, i.e., tense and heated with discussion of controversial issues and some tension when final recommendations were being presented. One person felt that a last minute change of the Council agenda when a task force was to present its recommendations created a sense of rejection of the task force by the staff.

Ability to make decisions

The majority felt the decisions were provider-oriented because of their experience, education and level of skills and because they attended sessions more frequently and in greater numbers. Some felt the objectives of the

Council were not clear and this affected the decisions. A few consumers felt that some decisions had been made prior to the meetings and that people from previous Councils were dominating the present Council. One consumer felt that consumers did not influence decisions, and therefore stopped coming on a regular basis. Another felt that as consumers became more informed they did influence decisions, and that it was important to keep attending sessions and representing the consumer perspective.

A few respondents expressed the lack of time as a negative factor in making decisions and that there were times when people agreed to things more readily because of their tiredness. The majority of consumers and providers felt the chairperson did a very good job in trying to reach consensus before a vote was taken in order to prevent a close split vote. They felt positive about the amount of discussion, the referral of items back to committee for more work or revision, and the fact that the minority vote or report was carried in the minutes. There was also a sense that the Council rubber stamped most of the things which came out of the task forces. One person suggested that the task force meet more frequently and the Council meet less frequently as the task force was where the real work was done. Several reported that the real decisions were made in the task force and not in the Council.

Again, in answering this question a couple of people expressed negative feelings toward outsiders who they felt lectured to them but expressed acceptance of information coming from the task force as they were their "own" people.

There was some uneasiness about the implementation of recommendations and that planning bodies do not have to live with their recommendations or outcomes of their decisions; what would be the long-range effects of their decisions and would all their work come to naught?

One person commented:

"The whole idea of health planning is a laughable joke with people making recommendations and no way to implement them. I didn't take it seriously. I felt the Council meetings were a good place to go when I had nothing else to do, but I felt others took it more seriously. It's impossible to make decisions with so many divergent views and people who have unclear roles; the role of consumer is self defeating, everyone talking and no one listening - but what can one expect with so many people."

Ability to work together

The majority felt there was definite movement toward the development and use of ability to work together as the group actually moved ahead with its tasks, felt people listened to each other, had respect for each other, and in areas of conflict there was time taken for discussion to resolve it. Some felt there was a division between providers and consumers which the providers created. The most-mentioned negative statement or uneasiness

expressed was that the Council was too big to be effective. One provider applauded the part of the consumer and felt a new era in health planning was coming, "Somewhat frustrating, but experts are no longer in exclusive control." Some felt that if the goals of the Council were clearer, the work of the Council would be more effective.

Sense of involvement

Most of the respondents felt the Council was struggling, not sure of its direction and leaned heavily on the staff at the beginning. As the Council became more experienced, most members fully realized that the role of the staff was to be a supportive one and not a directive one. The majority felt there was a high degree of commitment on the part of the members and one person indicated that there was usually 50 percent attendance as evidence of this commitment, thus using 50 percent as a positive criterion. They felt that those who attended the meetings showed honest concern for people and the process of planning. Several expressed concern about the low attendance at some of the meetings. To quote one,

"I liked the work the Council has done, but if I were king I would start replacing Council members with people with broad experience. I would have a rule about how much work they had to do, number of meetings, whether they were on task forces or not and get rid of the dead wood. Wouldn't even have me on, I've been on too long."

At the opposite end was the person who commented,

"I am very concerned about the short time people spend on the Council being long enough for them to really know what they are doing. This is especially true for consumers. Professionals have been trying to solve some of the problems for years and working at them full time, therefore, how do you expect some one new to health care to solve them? Six years should be the minimum for a person to serve on Council in order to be effective."

Some felt involvement increased as the task forces brought in their reports. Several reported staying overnight and that the workshops increased their sense of involvement. One member who had missed many meetings felt very badly about it as she had expected to be more active and indicated that illness, a change of priorities and the gas shortage were factors which contributed to her absenteeism. She hoped to make more meetings next year.

Question 7.

I would like to find out how you experienced the task force as a group. What was it like during the first couple of meetings you came to regarding such things as the way the task force made decisions, the atmosphere or climate, ability to work together as a group, sense of involvement, etc.? Did any of this change over the year? What occurred that helped bring about these changes?

As each task force differed both in membership and in content, so perceptions of the task forces varied across persons and the different task forces. The

range of attitudes toward the task forces and those factors apparently affecting member attitudes are reported below.

Although many respondents reported positive feelings toward their task force, there seemed to be an equal number of negative or at least non-committal responses.

Some people stated:

"Members worked together to make decisions. It (the task force as a group) seemed very reasonable to me."

"We had a good discussion most of the time and reasonable decisions based on the logic of the discussions."

"There was open discussion, respect for each other and the group arrived at group decisions."

"I think they really did a pretty good job."

Others expressed negative impressions:

"My own dissatisfaction lies in the discrepancy between the way I would like to see us work and the way we are actually working."

"I didn't feel it was a meaningful group because they weren't coming and when they did come the subject matter was hard to deal with."

"My lack of participation was a cross between plain disgust and difficulty in getting there."

Almost half of the members interviewed mentioned that attendance at task force meetings was low or that they themselves did not make many meetings:

"There was poor attendance, only about one-half of the members plus the staff attended any task force meeting."

"I have only been to one meeting and part of another."

"I quit going."

"The greatest number of people at a meeting was five."

"I copped out."

Of the people that had not attended many meetings, some stated that they had other commitments. Others said that they were "not motivated enough to take the time from something else to give to that" or "felt like I didn't want to interfere."

There were different effects of this lack of attendance on the task forces. One respondent said that a "core" group formed in his task force. "A year

ago when the task force began we had 50 percent attendance but of that 50 percent, we had 90 percent of them attending all through the year." Another respondent stated, "The task force has not functioned as a task force; it's disintegrated without anybody showing up. It's mostly staff work."

From these differences it would seem that attendance, in and of itself, was not the critical factor in the functioning of the task forces. Two factors did appear as very relevant to the level of task force functioning. One factor was the topic of the task force and the personal interest of the members in that topic. As several respondents put it:

"Not sure the topic is a subject a committee can control."

"Great deal of frustration until we could zero in on the problem."

"Commitment on our task force was good because of the personal interest of individual members."

"It really was not the group to come to grips with this particular subject."

"The other three members of this task force are deeply committed to this area."

The other factor which members mentioned as influential in their task forces was the style of leadership of the chairperson:

"We had a good leader who was totally interested in the problem, got staff to work, and was well-organized."

"Chairperson could have been more helpful, didn't use planning steps."

"The one person really committed was the chairperson."

"Chairperson did an excellent job."

"Leader drew out each person's view point."

"Personal input from the chairperson was very good."

"Felt group's ability to work together decreased with change of leadership."

If these two factors were positive, that is, if the members were interested in the topic and they had "good" leadership, they tended to report positively on the task force. That is, they felt involved, felt they worked well together, and felt good about their group's decisions. Comments were as follows:

"Got to know those who attended regularly."

"Felt comfortable with people as year progressed."

"Started out semi-formal, became 'kissin' cousins' by Christmas."

"Smaller, more intimate group...positive feeling among individuals."

"Our decisions were well thought through and reflected all of us."

If these two factors did not come together, the task force tended to be viewed as a negative experience.

Question 8.

I would like to find out how you experienced the many different people on the task force. At the first couple of meetings you attended, how many members did you know, how did you feel toward them, how did you feel toward the others you did not know? Did any of this change for you over the year? (If yes, ask person to state what changed.) What occurred that helped bring about this change?

The results for this question are reported by discussing the responses organized under four subheadings related to the question.

How many members did you know?

A majority of the respondents answering knew less than half of the members of their task force at the beginning, while only a few reported knowing all or most of the members.

How did you feel toward them?

Generally, the members expressed initially positive feelings about the other members of their task force group:

"Felt they were all concerned and dedicated."

"Very much a congenial feeling."

"People were seriously concerned with the issues."

"Felt they were very dedicated people who wanted to do a good job."

The few initially negative feelings expressed about other members concerned mainly their lack of knowledge about a particular area. These came mostly from providers:

"Not a very clear sense of what they were there for...."

"There was a lot of educating to do."

"It's extremely difficult to try and explain your experience over the years."

"I wondered why they were on this task force...a long educational process was necessary."

Did any of this change for you over the year?

Over the year people tended to see changes in a positive direction, in terms of knowing more of the people in the task force, getting friendlier and generally relating better.

Most people ascribed these changes to the effect of spending time working together in a small group. It also seemed to the members that the character of the relations between members was set at the beginning and developed in the same direction over the year:

"We started high in cohesiveness and maintained it."

"Pretty open right from the beginning, got a little freer."

"Were able to share our ideas more than at the Council meetings."

"It was good to have the informality inherent in small groups-- but this really occurred almost from the beginning and hasn't changed."

"Nothing specific to account for getting to know each other except time and general process of a group."

"Felt very warm toward them even at the beginning."

"Gradually acquired appreciation for those who exposed themselves."

"No change in likes or dislikes of persons."

"Acquaintance with them followed the same pattern as at Council meetings."

What occurred that helped bring about this change?

Some of the things that were mentioned that enriched the personal and work relationship between members were:

"Once we confined ourselves to one or two topics, people relaxed."

"People who had no knowledge became more knowledgable."

"People began to realize that things couldn't happen fast."

"Got to know them by talking with them informally over a few drinks."

"Overnight sessions seemed to work out better."

"Informal and night and weekend meetings helped knowing each other and working relationships."

So it seems that the members felt that their relations with other members on the task force were pretty much established at the beginning and either improved or did not change over the year. Forces which appeared to facilitate the

improvement of relationships were opportunities to work more closely and informally in a small group, a clearer and more contained focus on the task, an increase in knowledge of those who needed it, a growing appreciation for the time needed to resolve issues and a resulting reduction of impatience, and the risk-taking of members to disclose their individual perspectives and ideas.

Question 9.

I'd like to ask you about your views of the staff. Regarding the two persons that worked with your task force, at the beginning how well did you feel you knew them? How helpful or unhelpful do you feel they were? Did this change? What brought about the change? (Do same as above for Council, in reference to total OHMA staff.)

The information under this question is presented first in regard to the task force staff and then the OHMA staff.

Regarding the Task Force Staff

Almost all of the respondents reported that they had not known the staff people at the beginning of the year but they were almost unanimous in their praise of the work done by the staff in support of the task forces:

"This staff member knew where he wanted to go and how to get there."

"Tremendously helpful, they are very effective."

"Not dominating."

"We couldn't have done it without the staff."

"They made it easy for those who didn't have the intimate knowledge to be involved."

"Staff made you feel they wanted you there."

"Very helpful."

Some of the things that members thought the staff did to help were as follows:

"Staff did all the writing, took it all down, organized it and wrote it up."

"After some abortive meetings, the staff moved in and assisted the task force in going through problems systematically."

"Organized information. Functioned as encouragers."

"Related to individual members more closely."

"They step in and do what they are supposed to do and step back and let us work. They stay out of the whole decision making process."

"One staff member recognized the basic differences between migrant workers and native Americans and made an effort to accept and deal with these differences on the task force."

One shortcoming that was pointed out was the lack of knowledge and experience of some of the staff with a particular task force topic. Yet at the same time, it was also mentioned that "they worked very hard to acquire that knowledge." Some members were satisfied with the expertise gained by the staff members, while others would have liked a "more experienced staff." However, these comments were sparse and, in general, the staff was seen as consistently effective over the year, if not better at the end.

Regarding the Office of Health and Medical Affairs Staff

About 10 people reported that they did not get to know the staff, three reported they grew to know the staff somewhat well, with the majority reporting that they got to know the staff well over the year. Both consumers and providers felt the staff was very helpful with comments from "extremely helpful" to "the Council could not have functioned without them." The consumers were more general in their comments, e.g., "felt they worked hard," "were cooperative," "responded to requests," "made me feel welcome," and "they were friendly people." However, one person felt that one staff person came on too strong, described that person as efficient, and hard driving, but who needed to use more tact in dealing with the Council. Another felt that the staff were good people trying to do a good job but not sure if they had proven their skills. This same person said, he was not clear about the Director's role in the Council.

The providers, while expressing mostly positive feelings, seemed to be a little more specific and critical. One person said he really did not know "who was who" and would have loved to see an organizational chart, while another saw positive growth in the organizational structure and assignments of staff and also felt this staff was better attuned to the present Council than past staff.

Many people referred to the Assistant Director for Planning as being "excellent," "responsible for the improvement," "a great guy," and "prime mover." Much respect was expressed for the staff's ability to summarize and organize data, prepare materials before and after meetings, and respond to specific requests. While understanding the large extent to which the staff had already streamlined "volumes of information," several members still experienced an information overload and suggested it would be helpful if they could summarize even more information.

Any negative comments about the staff were made by providers with the most negative comments coming from a person who had taken the whole process "as a joke." For this person, it seemed that other hidden issues may have been in operation beyond his actual experience on this Council.

One person specifically mentioned he enjoyed the procedures used to both assess the Council functioning and to feed the assessment information back to the Council.

Question 10.

Lastly, and this may, at first hearing, sound a little strange, in what ways did your experiences with the Council affect you as a person? What did the experience do to or for you?

Under this question, the number of persons who reported that they were affected in some noticeable way and those who were not are presented. Further descriptive information is provided about persons in each of these categories.

<u>Categories of Response</u>	<u>Number of Responses</u>
In a noticeable way	31
Not in a noticeable way, but with qualifications	6
Not in any noticeable way	2
Total Responses	39

People affected in a noticeable way by Council experience.

Members who felt that the Council experience affected them in a noticeable way gave many varying effects. These members largely felt that the effects had been positive.

The areas in which members felt they were influenced were as follows: new perspectives, skills, ideas/knowledge, personal growth/self-awareness, interpersonal relations, professional growth/action taken outside Council. Example quotations from member interviews are included under each heading in order to further clarify these effects.

New Perspectives

Respondents who indicated that the Council experience has given them new perspectives primarily cited perspectives related to issues of minorities or the poor and perspectives related to health issues. A third category of general perspectives is also included.

Minorities/Poor

"(The experience) gave me the thought that someone, somewhere ought to assure that the basic needs of some are met...so a minority or migrant worker can get help...I was probably ignorant before and never paid attention until I was exposed to it... Here's a bunch of nomads, still human beings, and nobody to help them at all."

"Recognizing that real inroads are going to involve whole social change in the way society looks at poverty and racism ...health care is not going to solve all the problems...."

Health Issues

"Bridging gaps between professional and nonprofessional must be done before working toward health solutions."

"I have become aware of limitations that face the...health field in accomplishing goals."

"I have a greater appreciation of the cost of services."

"I became aware that people, especially doctors, wanted to do things for people." (respondent a consumer)

"I had an opportunity to expand work on local health problems to a statewide level."

"Health, like other social issues, start at the top, and it is more political than I thought it way."

"I have a much more clearly defined picture of what health services mean."

"The main thing I saw was that it (the Council) was a forum for all segments of the health care problem to come together... more, than, the planning aspect...without the necessity of unanimity."

"I do recognize for the first time as the result of my position on Council that there are many places in the state where medical assistance doesn't come easy."

"It brought home to me that the problems we are plagued with at this level (regional) could be solved in Lansing, if people wanted to deal with it and not make a political issue of it."

"Broadened my outlook and made me aware that health needs of other people are not just the health needs of my area or my people. Also, it has given me a better idea of doctors and other people in health."

"We have a nation-wide health program problem. Other nations rank higher in providing care."

General Perspectives

"I've come away from meetings being dead-center on something and feel, 'Well, now I've got a handle on this,' and I think I can begin to move. So, I'll get some people together to talk about this and see what we can do."

"In terms of understanding social process and the way the society gets from one point to another has been extremely revealing, and it makes it easier to understand how people become impatient with the social process."

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"Involvement in the Council developed a sense that a lot of things in the system need to be changed or we want for people to get that they can be obtained."

Skills

"The effect on me, personally, is in terms of my ability to manage meetings and to move large groups toward consensus."

"Now I feel I can do health planning for myself and also help others by giving them information for helping them plan for themselves."

"I did not develop any new skills, unless you mean communication on the Council."

"I learned how to deal with people."

"As a person, and as a community organizer, it helped me understand how to use the political process better."

Ideas/Knowledge

"I've gotten insight into a completely new field. I've enjoyed learning about the health field."

"It provided information that wasn't generally known to me."

"All the positions I held show a gain in knowledge that can be used in any or all other committees."

"It made me more knowledgeable on health needs and on the whole state and of the people who live in Detroit or Flint."

"I felt much more knowledgeable and at ease with the system--the governmental system and how it functions, the political process, and this was valuable to me as an individual."

Personal Growth/Self-Awareness

"It's given me confidence. This is one of the first things I've done on my own. My other political work was always in someone else's shadow."

"It helped greatly. I think it's expanded my mind considerably in terms of social issues and frustration."

"It made me feel perhaps I knew more than I thought I knew about health problems."

"I developed self-assurance in giving information to people... felt able to discuss information I got from the Council...."

"Makes you far more aware of yourself as a person...and makes you grow and mature...." (Coming to know different people on the Council)

Interpersonal Relations

"I've reaffirmed old friendships and made new ones...it's a great place to rap with people...I enjoy the give and take...I feel accepted there...I enjoy them."

"I've also enjoyed meeting the people. I've made some friends and I look forward to going to the meetings now, where I dreaded them at first, because I look forward to seeing my friends again."

"I consider some Council members as friends now, in a professional sense...the people, in general, were very good and knowledgeable...."

"I'm getting to know people."

"I made new friends on a broad scale, personally and professionally."

"I got much more out of talking to the individual members of the Council than in reading the material that was provided."

"It's given me an opportunity to sit and listen to other people's ideas."

"Personally, it has given me more insight into the people on the Council. Getting to meet them has been a nice personal experience for me."

Professional Growth/Outside Council Activity

"I've gotten involved in communicating the information I've learned. It's a spin-off from the Council. I make Council materials available to my people and urge that they return to their own organizations and give this information to other organizations."

"My direction (within own professional organization) has been altered somewhat, as far as priorities...because of the Council."

"It helps me in my professional role and the decision-making there."

"It helped me work better in my agency...able to make appropriate referrals for children...."

"I can go back to my friends in the community and try to help my community take the best from what has been suggested by the task force groups and bring them back from my community and help them on a state level."

One member indicated being upset by the inadequate training of emergency medical people which he learned from the Council experience which prompted him to return to his own community and start a campaign to upgrade standards of training.

While one member felt affected in a positive way by the experience, this member also indicated frustration over the amount of work and time required of Council members, as well as the lack of any personal feedback as to whether this member's contribution to the Council was meaningful and worthwhile to the Council.

"I've felt a little frustrated with all the work to be done. It has taken more time than I thought...time almost prohibitive...I keep wondering how worthwhile I am. Does it really mean anything when I go?...I've gained and benefitted but I don't know if the Council has."

A number of members indicated the time pressure and the amount of outside reading required was at times a source of frustration.

People Not Affected by Council Experience in any Noticeable Way,
But with Qualification

Six members stated that the Council experience has not affected them in any noticeable way, but then qualified the statement by mentioning at least one kind of effect. Some of their responses follow below.

"I did not change my concept of the relative efficiency of governmental units...but was impressed by the quality of people in state agencies...but the political system hampers this...Council not a help here...I got to know one or two people, nothing else."

"I don't think it's done anything for me or to me...it's one more meeting among thousands of meetings...I'm pleased to be on the Council...it gives me a much better feeling of what's going on at the level of state health planning than any other means of finding out would...."

"It hasn't changed my life greatly, since it's not significantly different from most of other things I've been doing elsewhere...of what I know about state health planning, I think the service on the Council has contributed 10 or 15 percent of it, but I do this for a living, and the Council is a supplement."

"It had no impact whatsoever...well, in the task force, I thought about a few things I wouldn't have thought of. The task force was fairly interesting."

People Not Affected by Council Experience in any Noticeable Way

Two respondents indicated that their experience on the Council did not affect them in any noticeable way. One member indicated that a realization of personal effects might come later.

"The effect comes when the position is finalized. I can't think of any way I've been substantially or materially affected by the experience."

The other respondent felt that the lack of any effect from the Council experience was due to the many varied past and present experiences of this member.

"It may sound smug, but because of my professional background and experience I'm having difficulty in identifying anything that changed me."

This member stated that since he is involved in so many other groups, it was difficult to know if there was really any effect or change at all as a consequence of this one. He also indicated that it was difficult for him to find time for the Council.

From responses to Question 10, it seems clear that most members felt some noticeable impact from the Council experience upon their professional and/or personal lives, and that the impact ranged from very significant to something just mentionable. For those who felt a qualified impact or no impact at all, it appears that their own self-perceived expertise and current and past experience with other similar groups were strong factors which precluded the likelihood of this Council making a meaningful entry into their professional or personal lives. As one member put it, "I had no expectation of being personally affected."

Information Beyond the Ten Questions

During the interview, Council members shared much information which did not fit under the 10 question areas, but which is helpful in understanding the Council experience during the year 1973-74 and for future planning. It is presented below under five headings.

Regarding membership and member relationships.

A member mentioned how helpful it had been to get to know her task force members better. It was suggested that assigning Council members to different tables at lunch so they would mix rather than stay with groups of friends could facilitate better Council interpersonal relations. The result could be a better functioning Council. Quotations of note:

"There continues to be a problem of adequate education for the consumer to give everybody the feeling of equality."

"It would be helpful if the consumers could meet together as a group by themselves. This would increase unity and confidence."

"Need more workshops and way for orientation and getting to know each other...should have an idea of why people on Council are doing what they are doing."

"The Council should be more explicit in talking at grassroot level. Professionals used terms consumers did not know. Glossary was helpful, but it could be expanded as providers did not know all of the abbreviations either."

"A lot of education is necessary for the Council. I have mentioned this to staff and a retreat has been planned which should be helpful."

"Felt the Council did not take the responsibility to educate the consumers. The staff is attuned to that problem."

"I felt inadequate especially because I didn't understand the strong feelings expressed about some of the legislation. It made me feel I am missing something."

"Needs to be a provision to turn over the Council membership. If plateau of knowledge is reached, there is a decrease in interest... so replacement is important."

"Council was better before we had so many hot shots on it. They have overwhelmed the consumer. Lesser lights are more able to speak freely."

"In regard to hot shots, if they approve a thing, then they may have some obligation to support it later."

"Director's newsletter to give a broad perspective of where we are going."

"Need some orientation to what is going on so you can vote."

"Should be more consumers."

"I was taken aback by the bigwigs and did not want to take part."

"Migrant and Native American task force people were divided among the minority groups."

"Men must become more sensitive to women's issues and involvement of women on the Council."

"It was bad enough for me sitting up in the piney woods and coming in as an M.D. to avoid being snowed under by three university deans of medical schools, the Director of Public Health and the Director of Mental Health. I can resist that because I'm doing my own thing and I like it."

"There is a struggle for the soul of the Council. Is it to be the resource of what is already available, or if it were constituted of lesser people might the Council get back to counseling."

"Where is an M.D. who works in the ghetto? Where is a nurse who works in a migrant labor camp? Instead we get professors of nursing."

"Don't like the idea of not identifying who people are and why they are talking, it's like getting a wrong number phone call."

"I'm there because someone might want my ideas about health care."

"My own interest and concern in the Cost Containment Task Force is just not one that turns me on so when there were meetings I was not there. Its ranking in my own personal priorities was low."

Regarding implementation of recommendations.

"I have felt anxiety for something to be done...and how we're going to do it and where we're going to get the money. This seems to be one of the biggest problems all over...who's going to do it?"

"I'm concerned with implementation...to what extent does the Council have the authority to put out important information, for example on maternal and child care. The reports are turned in, reported to the Governor and details are extensive and authenticated with recommendations, but the legislation is another ballgame. We need to educate the legislators, but when it's passed as law, then who picks up the program to see that it's implemented, to see that people who need services are aware it's there? I think it's essential that we communicate what we're doing to other organizations."

"Immensity of job is overwhelming. Wonder how much of it is going to be implemented. Shouldn't there be more or some involvement with the legislative part of health planning."

"OHMA has no power or authority to get recommendations implemented."

"Uncertain about what's all going to happen with the time we spent."

"I wish people would have a little more sense of political realities so as not to duplicate the efforts of the other groups. We sometimes didn't consider budget realities of what could really be implemented politically. You have to balance two factors when you're trying to develop new plans--budgetary considerations--and planning."

This member felt that staff could provide such budgetary information. He felt that it was important to balance two things--the dreams, which shouldn't be limited by reality in the planning stage, with the reality, budget and politics in such a way that you get creative ideas which are realistic enough to have a chance to be implemented. He hopes that people could learn to do this without becoming defeated when their "dream" is tempered and modified by realistic considerations.

A member felt that staff could provide more information to give members the necessary overview of the financial and political realities in which the Council recommendations are to fit.

One member felt that planning was too abstract and the issues dealt with were too broad. Another stated that cost containment was much too broad an area to have been handled within the task force.

Regarding the Advisory Council as an agency within the state.

"There is no question that the majority of people and especially providers don't know anything about the Advisory Council, and therefore don't think much about it. Somehow there has got to be a public information effort in the Office. This information has got to get out. If I were not a member of the Council, I would see and hear nothing about it."

A member indicated that in years past, the Council did not have a good public image, due to the second and third string professionals on the Council. Now that the Council has such good people on it, he feels that the Legislature may still be relating to them as in the past. He would like to communicate a new image of competence. Then, the Legislature would begin to utilize them as a valid resource, rather than duplicating the Council's efforts by setting up committees that do what the Council does.

"I do think the tenuous nature of the Council is detrimental."
(tenuous: laws will change, funding may not be extended, change in Governor).

"Might make the Council more apolitical and not appointed by Governor or political branch of government. This might give more stability."

"Would like to see Council exist by legislation rather than Executive Order."

"Council originally started as advisory to a high-powered commission. Council advised the commission to go out of business because it was useless, too much special interest. Now this present Council is getting back into the same think with high-powered people."

"The Council took direction from staff (OHMA) and staff took direction from Governor, but staff should take direction from Council and Executive Committee."

Regarding the conduct of Council sessions.

"Less formal presentation, more issues placed upon the table, and use the Advisory Council members in their role as advisors with whatever background they begin with."

"More spontaneity and freer ideas if we aren't programmed...."

Further responses.

One member was very disturbed by the conflict of interest policy adopted by the Council. He felt it should be retracted.

"If a Council member had any gain to achieve, he couldn't discuss or even vote on it...."

"If I can't express my views, there's no sense in going...If we were going to benefit by our actions, or there was going to be some financial reward, that would be different, but this is for the public.... It was almost like a slap in the face to us, really, I would like to see it retracted."

A number of members commented that they felt that the last two steps of the health planning process were seen by them to be steps of the implementation phase and not the planning phase.

"Nothing was said about mental health or mental retardation--it was just health, health, health. These are areas of need also."

"Feel higher priority to Council than task force."

"Real work done in task force."

One consumer expressed the desire that expense checks be forthcoming more rapidly as everyone did not have an expense account and this could be difficult for some people.

Actions Taken Related to Advisory Council Recommendations

Four reports containing Advisory Council recommendations on state health policy were produced in connection with the grant; one in October 1973 and the other three in the summer of 1974. Because evaluation of the project is being reported in August of 1974, it is possible only to report a partial list of actions taken related to these recommendations. In addition, examples of what may be expected are offered related to other Advisory Council recommendations.

Actions taken related to the October Policy Statement on Perinatal Intensive Care:

- Serves as a basis for capital expenditure review under the state Certificate of Need and federal Section 1122 of the Social Security Act by areawide comprehensive health planning agencies, and by the designated planning agency (Michigan Department of Public Health) and by the State Health Planning Advisory Council.
- Served as a basis for decisions by the Bureau of the Budget in consideration of the Department of Public Health's Program Revision Request for funds to implement a statewide regional program of perinatal intensive care services.
- Served as a guide in establishment of the Perinatal Association of Michigan (a private, nonprofit organization working with the Department of Public Health in implementation of a network of regional perinatal intensive care centers).
- Provided the basis of Advisory Council's support of legislation involving health insurance coverage of newborns.

Actions taken related to the June Policy Statement on Maternal and Child Health:

- Served as the basis for Advisory Council's review and support of a proposal to the Michigan Association for Regional Medical Programs to assist in quality assurance in abortion services.
- Served as the basis of Advisory Council's review and support of proposed legislation involving venereal disease education in public schools.

Examples of actions taken related to other Advisory Council recommendations:

Policy Statement on Emergency Medical Services

- Serves as the basis for review and comment on all project applications under the federal Emergency Medical Services Systems Act of 1973, P.L. 93-154).
- Serves as the basis for the development of the state EMS plan by the Michigan Department of Public Health.
- Provided a basis for legislative support of revisions in proposals for the licensure of advanced emergency medical technicians.

Policy Statement on Renal Disease

- Provided the basis for review of applications for exceptions for Medicare reimbursement for treatment of end-stage renal disease by the Office of Health and Medical Affairs and the Advisory Council.
- Served as a basis for the Governor's Program Policy Guidelines to the Department of Public Health on renal disease services, and as the basis for the development of the Program Revision Request on renal disease by the Department of Public Health.

VI. IMPLICATIONS OF THE PROJECT AND CONTINUING GRANT-RELATED ACTIVITIES

Implications

It seems quite clear from the quantitative and qualitative data presented in the preceeding chapter that positive consequences occurred for the Council as a group and for Council members as individuals. These consequences were increased competency of the Council as a health planning group and enhanced professional and personal development of Council members.

It is impossible to know the extent to which the Education and Development Project was responsible for such consequences, since there was no control group for comparison. Many Council members in many of their interview statements, in their responses to the open-ended question on each of the post-meeting evaluation questionnaires, and in unsolicited statements within Council meetings gave testimony to a relationship between positive consequences for the Council and project activities. Sometimes, this was stated as a comparison of this past year's Council experience with the experience of the prior year when the resources made possible by the project were not available. In addition, the project staff observed, on a consensus basis, specific consequences following their purposely planned activities.

In the absence of an experimental research design, Council member testimony and staff observations are the data upon which the following inferences are made.

First, the effort and financial expense directed toward the education and development of the Council resulted in some significant changes.

Second, several observations were made in the process of carrying out this project of which the Office of Health and Medical Affairs staff is aware and which can be applied to both the conduct of the Council in the coming year and to the conduct of other health planning advisory councils in other places.

A task-oriented council whose members' initial, collective expectations do not include learning about the dynamics of groups and about themselves as members of groups, can be helped to acquire significant learning in this area, which can in consequence assist in the group's effectiveness.

Council members' perceptions of the professional competence and support of the staff are significant factors in determining the extent to which they are receptive to staff attempts to conduct education and development activities.

Receptiveness of council members to staff efforts at education and development is increased to the extent that the purpose and method of the effort are clearly and openly shared and are perceived as useful. Non-receptiveness, and even resistance, is generated to increasing degrees as the purpose and methods of the effort become more unclear, covert or useless. Participation in planning, designing, implementation, evaluation, and feedback by council members create optimal conditions for receptiveness.

Adoption by a council of new practices which are inconsistent with past practices is strongly affected by the extent to which the council, as a group, can have an experience with the practice and the extent to which that practice is perceived as more helpful in moving the council toward its task objectives than its past practices. Concomitantly, when staff skepticism about council members' reaction to certain new practices is apparent it becomes less likely that council members will accept the new practice.

The level of attendance and active participation of members at meetings of a council and its subgroups is influenced by the perceptions which they have of the leader's helpfulness, their own level of interest in what is under consideration, their feelings of power to influence the results, and the degree to which they are not overawed by the perceived expertise of other members.

Heterogeneity in the backgrounds, roles, levels of expertise, assertiveness or submissiveness, sex, and length of tenure of council members is likely to produce more use of the resources of members if appropriate opportunities are provided for training in group membership (including orientation and member inclusion) and for informal contact at frequent intervals.

Although council members express continuing emphasis on the importance of task achievement, their desires for interpersonal contact, as a means toward both group identity and effective work relationships, are likely to be present but less emphatically and clearly expressed because there are no systematized avenues for the expression of interpersonal needs.

Broadly relevant information provided between and during council meetings is more likely to overload and overwhelm members than the communication of selected information aimed at target questions and issues of immediate relevance. Brief summaries of lengthy printed materials are helpful, especially to consumers. Glossaries of health and health-service terms and of terms used in the planning process help provide a common vocabulary for all members.

Council subgroups need more than broad goal statements or issues in the charge given them initially. If, wherever possible, specific objectives related to the issue are delineated in advance much time and effort can be eliminated.

A carefully chosen primary consultant who is a recognized expert in the area of concern and who is hired on a part-time, as-needed basis can be effective in assisting council subgroups in their work.

Wide dissemination of first-draft or preliminary recommendations by council subgroups before the drafting of final recommendations not only can capture the reactions of some interested and to-be-affected groups, but also can prepare the way for eventual consensus on desired change and methods for its accomplishment.

Continuing Grant-Related Activities

Although the major portion of the work planned for the Advisory Council Education and Development Project was completed at the end of the grant year, several activities will be continued or are being developed as a result of the project.

By design, the project had long-term implications for a continuous process of Council education and development. Appropriate components are being built into the ongoing operation of the Advisory Council and the Office of Health and Medical Affairs. For example, guidelines to the health planning process are being developed, based on project experience, for all new Council task forces and committees.

Eleven new members have been appointed to the Council who can benefit from a more than cursory orientation to the recent and current work of the Council. By circumstance, most of the new members are consumers. Education on the health delivery system and the relationships of its components is in process as well.

The Advisory Council and the Office of Health and Medical Affairs are now engaged in developing a state health plan. As part of the 314(c) grant project, a workshop on "What Is a State Health Plan" was conducted in February, and it became evident that considerably more work in this area would be desirable during the next year. A September Council meeting and an October retreat are scheduled at which time work on state health plan goals and priorities will be undertaken.

Pending federal legislation may soon radically alter the composition and nature of the Advisory Council, thereby requiring new and different educational efforts.

APPENDIX A

AUTHORIZATIONS

Governor's Letter 74

Notice of Grant Award 76



STATE OF MICHIGAN

OFFICE OF THE GOVERNOR

LANSING

WILLIAM G. MILLIKEN
GOVERNOR

April 19, 1973

Robert E. Kinsinger, Ph.D.
Vice President
W.K. Kellogg Foundation
400 North Avenue
Battle Creek, Michigan 49016

Dear Doctor Kinsinger:

I am very pleased that you are serving as the Acting Chairman of the State Health Planning Advisory Council in Dr. Hunt's absence. I am confident that, under your direction, the new Council can have a major role in determining health priorities and formulating public policy which will be responsive to the needs of the people of Michigan.

While I recognize that the Council has a broad range of responsibilities, I would like to have it give major attention to three specific, substantive areas in the coming year. The first is the need to develop a state policy on the extension and improvement of health services to mothers and children. I am sure that you are aware of the suggestions that Dr. Hunt forwarded to me in this regard. Dr. Hunt believes that it is timely for the Council to identify and document maternal and child health problems in Michigan, recommend appropriate state policies with regard to services needed and suggest alternative programs for implementing these policies. I fully agree and ask the Council to prepare such a report for me by September 1973.

The second area which I would like the Council to consider at this time concerns the future development of the Medicaid program. Since mid-October, a liaison committee representing my Office and the Michigan State Medical Society has been examining problems surrounding this, our largest, single public medical care program. While the most immediate problems have been resolved, there are larger issues which must be considered. The Advisory Council, with its broad representation, is ideally suited to secure the views and opinions of both consumers and the major health care provider groups of the state in order to determine ways and means in which the program can be improved. It would be helpful to me if this report could be prepared by December 1973.

Robert E. Kinsinger, Ph.D.

Page 2

April 19, 1973

The third specific area for the Council's consideration is the development of measures directed toward cost containment in the health care field. I would urge that the Council review the interdepartmental Technical Work Group report, "Rising Medical Costs in Michigan: Scope of the Problem and Effectiveness of Current Controls." This report is a valuable resource document containing a substantial amount of data concerning the economic basis of medical and dental care in this country and a series of recommendations for change. I would like the Council to consider this report and the larger issues, including the concerns of health care providers and the attitudes of consumers, and to develop a cost control strategy to be submitted to me by February 1974.

I recognize that these are major assignments which will require a great amount of time, effort and staff support. I am sure that, with the assistance of the Office of Health and Medical Affairs, the Council will be able to produce viable alternatives for state policy. I look forward to receiving the recommendations of the Council in these three areas, as well as others that it may consider.

With personal regards.

Sincerely,

Governor

JUL 2 1973

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

NOTICE OF GRANT AWARD

Under Authority of Federal Statutes and Regulations, and HSMHA
Policy Standards Applicable to the Following Grant Program:
314(c) of PHS Act as Amended

1. DATE ISSUED (Mo., day, yr.) 6/29/73	2. CATALOG OF FED. DOM. ASSIST. NO. 13.208
3. SUPERSEDES AWARD NOTICE dated _____ except that any conditions or restrictions previously imposed remain in effect unless specifically rescinded.	
4. PROJECT IDENTIFICATION NO. CP-D 000090-01-0	5. ADMINISTRATIVE CODES CP D01 N 0
6. PROJECT PERIOD From 7/1/73	Through 6/30/74
7. BUDGET PERIOD From 7/1/73	Through 6/30/74

8. TITLE OF PROJECT (OR PROGRAM) (Limit to 53 spaces)
Advisory Council Education and Development

9. GRANTEE (Name and Address)
Office of Health & Medical Affairs
Executive Office of the Governor
State of Michigan
Lewis Cass Bldg., 2nd Floor
Lansing, Michigan 48913

10. DIRECTOR OF PROJECT (PROGRAM OR CENTER DIRECTOR, COORDINATOR OR PRINCIPAL INVESTIGATOR) (Name & Address)
George J. Durak, Admin., Officer
Executive Office of the Governor
Lewis Cass Bldg.
Lansing, Michigan 48913

11. APPROVED BUDGET FOR HSMHA FUNDS

BUDGET CATEGORIES For items identified by Asterisk*, see remarks	FINANCIAL ASSISTANCE A	DIRECT ASSISTANCE B
a. PERSONAL SERVICES	\$ 59,357	\$ -0-
b. PATIENT CARE		
c. EQUIPMENT		
d. CONSTRUCTION		
e. OTHER: <u>Cons. Serv.</u>	15,000	
(Specify)		
<u>Travel &</u>	15,000	
<u>Supplies</u>		
<u>Contract</u>	30,643	
ALL OTHER _____	-0-	
f. TRAINEE COSTS		
g. TOTAL APPROVED BUDGET	\$ 120,000	-0-

12. SOURCE OF HSMHA FINANCIAL ASSISTANCE

a. APPROVED BUDGET (11 g. Col. A)	\$ 120,000
b. INDIRECT COSTS (RATE: <u>Under Negotiation</u>)	\$
Base: S&W - TADC of \$ _____	\$ 120,000
c. TOTAL	\$
d. LESS UNOBLIGATED BALANCE FROM PRIOR BUDGET PERIOD(S)	\$
e. LESS CUMULATIVE PRIOR AWARD(S) THIS BUDGET PERIOD	\$
f. AMOUNT OF THIS ACTION	\$ 120,000

13. REQUIRED GRANTEE PARTICIPATION %
☐ INSTITUTIONAL COST SHARING AGREEMENT
EFFECTIVE DATE _____
☐ INDIVIDUAL GRANT AGREEMENT _____ %
☐ MATCHING AGREEMENT _____ %
☐ OTHER \$ _____ ☐ NONE REQUIRED

15. RECOMMENDED FUTURE SUPPORT (Subject to availability of funds)

BUDGET YEAR	FISCAL YEAR	BUDGET PERIOD	TOTAL DIRECT COSTS
*			

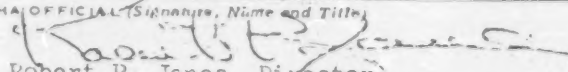
16. ACCOUNTABILITY FOR EQUIPMENT

☐ CONDITIONALLY WAIVED ☐ NOT WAIVED ☒ NOT APPLICABLE

17. FINANCIAL MANAGEMENT OFFICIAL (Title & Address)

George J. Durak, Administrative Officer
Executive Office of the Governor
Administrative Services, Lewis Cass Bldg.
Lansing, Michigan 48913

18. HSMHA OFFICIAL (Signature, Name and Title)


Robert P. Janes, Director
Comprehensive Health Planning Service
HSMHA

19. FOR HSMHA INFORMATION ONLY	a. PHS LIST NO. CP-20-73	b. PAYMENT SYSTEM ☐ HSMHA ☐ R.O. ☒ NIH	c. DIRECT ASSISTANCE FUNDS FY _____ \$ _____ FY _____ \$ _____	d. GRANTEE LOCATION CODES City: 2700 State: 26 County: 061 Cong. Dist: 84
	e. ACCOUNTING DATA 7530321 01-025591 3-3809204 41.21 HSM 50-4838 NIH 63-14620			

APPENDIX B

EVALUATION INSTRUMENTS

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ATTENDANCE RECORD
ADVISORY COUNCIL MEMBERS

6/28/74

Name and Affiliation	Advisory Council Participation						Task Force Participation		
	Provider or Consumer	Member Previous Advisory Council	# of AC Meetings Attended / # possible	Sent Substitute	Attended Workshop	Sent Substitute to Workshop	Task Force	# of Meetings Attended / # Possible	Sent Substitute
Allan Barth Michigan Hospital Assn.	P	X	8/10	2			HCC	9/9	
N. Lorraine Beebe Michigan Consumer Coun.	C		5/10				MCH	3/13	
Fred W. Bruner Mott Children's Health Center	P		9/10		X		MED	8/8	
Patrick J. Callihan Provincial House, Inc.	P		7/10				HCC	4/9	
Donald J. Carlyon Delta College	C	X	5/10				HCC	2/9	
John J. Coury Michigan State Medical Society	P		6/10		X		MED	3/8	3
Robert D. Coye Wayne State University	P		8/10				MED	4/8	
Rosa Torres-Dahya Mich. Women's Comm.	C	X	8/10	1	X		MCH	6/13	
Avis J. Dykstra Mich. Dept of Pub. Hlth.	P		7/10		X		MCH	12/13	
John A. Gronvall University of Michigan	P		4/10	1			HCC	4/9	
Barbara J. Grove Dowagiac News	C	X	6/10		X		MED	7/8	
Barbara H. Hammitt Housewife	C		7/10		X		MED	5/8	
Jack F. Hill Calhoun Co. Metro. Plng Committee	P	X	7/10	2		X	HCC	2/9	

Name and Affiliation	Advisory Council Participation						Task Force Participation		
	Provider or Consumer	Member Previous Advisory Council	# of AC Meetings Attended / # possible	Sent Substitute	Attended Workshop	Sent Substitute to Workshop	Task Force	# of Meetings Attended / # possible	Sent Substitute
R. Bernard Houston Dept. of Social Services	P	X	2/10				MED	2/8	2
Paul L. Hubbard Community Service Committee of New Detroit	C		9/10		X		MCH	8/13	
Andrew D. Hunt Michigan State Univ.	P	X	6/10		X				
Daniel J. Kehoe Blue Cross of Michigan	P		8/10	2		X	HCC	7/9	1
Jack A. Keller Resigned Ford Motor Company 4/74	C		3/6				HCC	2/6	
Harvey A. Kenney Municipal Fin. Consult.	C	X	9/10				HCC	6/9	
Robert E. Kinsinger W. K. Kellogg Foundation	C	X	8/10				HCC	3/9	
Shannon L. Madison Whirlpool Corp.	C	X	2/10				HCC	0/9	
Myron S. Magen Michigan State Univ.	P		7/10				MED	6/8	
Bonita C. Meshigaud College Student	C	X	5/10				MCH	0/13	
Ruben Meyer (app't Sept 1) University of Michigan	P		6/9	1	X		MCH	9/13	
ert C. Moore ...A.O.P. & S.	P		3/10				HCC	4/9	
Arnold Mouish V.A. Hospital	P		8/10	1	X		HCC	5/9	2

Name and Affiliation	Advisory Council Participation						Task Force Participation		
	Provider or Consumer	Member Previous Advisory Council	# of AC Meetings Attended / # possible	Sent Substitute	Attended Workshop	Sent Substitute to Workshop	Task Force	# of Meetings Attended / # Possible	Sent Substitute
Winston B. Prothro Kent Co. Health Dept.	P	X	10/10		X		MCH	9/13	
Agnes W. Rambo Mental Health Board	C	X	8/10				HCC	6/9	
Maurice S. Reizen Dept. of Public Health	P	X	6/10	2			MED	2/8	4
e R. Robertson Macomb Co. Comm. College	C	X	7/10				HCC	2/9	
Clara W. Rutherford Cent. Det. School Bd.	C		3/10				MED	1/8	
Jean E. Schlee Homemaker	C		7/10		X		MCH	11/13	
Frank L. Stulen Belfour-Stulen	C	X	6/10		X		HCC	3/9	
James F. Tobin Obstetrics-Gynecology	P	X	8/10		X		MCH	10/13	
Mary L. Trucks Five-CAP	C		4/10	1			HCC	3/9	
Robert Tupper Blodgett Hospital	P		10/10		X		HCC	2/9	
Peter M. Wege Steelcase Inc.	C		9/10		X		HCC	8/9	
Daisy M. Williams Ginaw Co. Child Dev.	C		7/10		X		MCH	9/13	
E. Gordon Yudashkin Dept. of Mental Health	P	X	3/10	2		X	MCH	2/13	
Yung-Hsuan Chou (app: 3/74) Grace Church	C		4/4						

____ Consumer

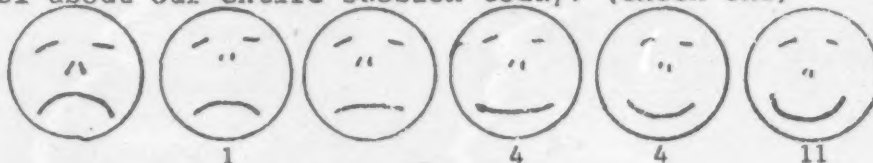
Advisory Council meeting evaluation
form used from 5/73 through 2/74

____ Provider

HOW DID WE DO?

1. How do you feel about our entire session today? (Check one)

Comments:



2. How do you feel about your own participation?

Very
Poor

Poor

Fair
Minus

Fair
Plus

Good

Very Good

Comments:

3. How much work do you feel we accomplished today?

Very
Little

Little

Some

Fair
Amount

Much

Very
Much

Comments:

4. How clear do you feel about the overall task of this council?

Very
Unclear

Quite
Unclear

Somewhat
Unclear

Somewhat
Clear

Quite
Clear

Very
Clear

Comments:

5. How clear do you feel about your own role and responsibility in the work of this council?

Very
Unclear

Quite
Unclear

Somewhat
Unclear

Somewhat
Clear

Quite
Clear

Very
Clear

Comments:

6. What prospects do you hold for this council?

Very
Low

Quite
Low

Somewhat
Low

Somewhat
High

Quite
High

Very
High

Comments:

7. Suggestions for future council sessions:

HOW DID IT GO TODAY?

I am a: Consumer _____
Provider _____

Please extend the line of each boxed item into the ring of the circle that indicates your answer to that item.

The session today

My feelings about being a part of the council today

The extent to which members seemed to listen to each other

My feeling of investment in what we were doing

My clarity about the overall task of the council

My clarity about my own responsibility on the council

Prospects I hold for the council

?

My own participation

What we accomplished today

My level of understanding of what was going on

The influence I felt I had in the session

?

Very Poor

Quite Poor

Fairly Poor

Fairly Good

Quite Good

Very Good

Quite Good

Fairly Good

Fairly Poor

Quite Poor

Very Poor

Also, I'd like to say:

HOW DID WE DO?

Scale of 1 (lowest) to 6 (highest)

(N=22)	(N=19)	(N=22)	(N=12)	(N=17)	(N=19)	(N=15)	(N=15)
<u>May</u>	<u>July</u>	<u>Sept.</u>	<u>Nov.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>Mar.</u>	<u>Apr.</u>

How do you feel about our entire session today?

How do you feel about your own participation?

How much do you feel we accomplished today?

How clear do you feel about the overall task of this council?

How clear do you feel about your own role and responsibilities in the work of this council?

What progress do you hold for this council?

My feeling about being a part of the council today

My feeling of involvement in what is being done

My level of understanding of what was going on

The extent to which members seemed to listen to each other

The influence I felt I had in the session

Also, I'd like to say:

(Comments listed here)

HOW DID WE DO?

COMPARISON OF CONSUMER AND PROVIDER RESPONSES

May

(N=5) (N=6)
Consumer Provider
(3 unidentified responses)

1. How do you feel about our entire session today?
2. How do you feel about your own participation?
3. How much do you feel we accomplished today?
4. How clear do you feel about the overall task of the Council?
5. How clear do you feel about your own role and responsibility in the work of this Council?
6. What prospects do you hold for this Council?
7. My feelings about being a part of the Council today.
8. My feeling of investment in what we were doing.
9. My level of understanding of what was going on.
10. The extent to which members seemed to listen to each other.
11. The influence I felt I had in the session.

(Brief analysis of responses here)

POLICY STATEMENT ON PERINATAL INTENSIVE CARE

Recommendation

Your Feeling About This Recommendation

	+	-	?
1	—	—	—
2	—	—	—
3	—	—	—
4	—	—	—
5	—	—	—
6	—	—	—
7	—	—	—
8	—	—	—
9	—	—	—
10	—	—	—
11	—	—	—
12	—	—	—
13	—	—	—
14	—	—	—
15	—	—	—
16	—	—	—
17	—	—	—
18	—	—	—
19	—	—	—
20	—	—	—
21	—	—	—
22	—	—	—

ADVISORY COUNCIL INVENTORY

LEGEND:

- 0 = I have no idea about this at all;
- 1 = I would never expect them to;
- 2 = Most of the time they will not;
- 3 = I would not count on them to;
- 4 = I would usually expect them to;
- 5 = Very typically I expect them to;
- 6 = They can always be counted on to;

This questionnaire tries to get at how you think the other members of the COUNCIL relate to you as a member. Below are a series of statements, and then to the left of each statement is a set of numbers; each number represents a different attitude as explained in the Legend.

Please read each statement and then circle the legend number to the left of that statement that indicates where you think most of the COUNCIL members are regarding that statement. Please don't use the 0 response unless you really have to. Thank you very much.

0	1	2	3	4	5	6	level with me.
0	1	2	3	4	5	6	Get the drift of what I am trying to say.
0	1	2	3	4	5	6	include me in what's going on.
0	1	2	3	4	5	6	accept me for what I am.
0	1	2	3	4	5	6	feel free to let me know when I irritate them.
0	1	2	3	4	5	6	perceive what kind of person I really am.
0	1	2	3	4	5	6	be interested in me.
0	1	2	3	4	5	6	act "judgmental" with me.
0	1	2	3	4	5	6	keep things to themselves to spare my feelings.
0	1	2	3	4	5	6	misconstruct things I say or do.
0	1	2	3	4	5	6	interrupt or ignore my comments.
0	1	2	3	4	5	6	ridicule me or disapprove if I show my peculiarities.
0	1	2	3	4	5	6	be completely frank with me.
0	1	2	3	4	5	6	recognize readily when something is bothering me.
0	1	2	3	4	5	6	respect me as a person apart from my skills or status.
0	1	2	3	4	5	6	provide an atmosphere where I can be myself.

CODE NUMBER

TASK FORCE INVENTORY

LEGEND:

- 0 = I have no idea about this at all;
- 1 = I would never expect them to;
- 2 = Most of the time they will not;
- 3 = I would not count on them to;
- 4 = I would usually expect them to;
- 5 = Very typically I expect them to;
- 6 = They can always be counted on to;

This questionnaire tries to get at how you think the other members of your TASK FORCE relate to you as a member. Below are a series of statements, and then to the left of each statement is a set of numbers; each number represents a different answer as explained in the Legend.

Please read each statement and then circle the legend number to the left of that statement that indicates where you think most of your TASK FORCE members are regarding that statement. Please don't use the 0 response unless you really have to. Thank you very much.

0	1	2	3	4	5	6	level with me.
0	1	2	3	4	5	6	get the drift of what I am trying to say.
0	1	2	3	4	5	6	include me in what's going on.
0	1	2	3	4	5	6	accept me for what I am.
0	1	2	3	4	5	6	feel free to let me know when I irritate them.
0	1	2	3	4	5	6	perceive what kind of person I really am.
0	1	2	3	4	5	6	be interested in me.
0	1	2	3	4	5	6	act "judgmental" with me.
0	1	2	3	4	5	6	keep things to themselves to spare my feelings.
0	1	2	3	4	5	6	misconstrue things I say or do.
0	1	2	3	4	5	6	interrupt or ignore my comments.
0	1	2	3	4	5	6	ridicule me or disapprove if I show my peculiarities.
0	1	2	3	4	5	6	be completely frank with me.
0	1	2	3	4	5	6	recognize readily when something is bothering me.
0	1	2	3	4	5	6	respect me as a person apart from my skills or status.
0	1	2	3	4	5	6	provide an atmosphere where I can be myself.

CODE NUMBER

Scoring the Inventories

Each inventory contains sixteen items, four items contributing to a score on each of the four dimensions. The first, fifth, ninth, and thirteenth items comprise the dimension of genuineness; the second, sixth, tenth, and fourteenth make up the dimension of understanding; third, seventh, eleventh, and fifteenth are for valuing; and fourth, eighth, twelfth, and sixteenth for acceptance.

Each item is scored from 0 to 6, depending on the council member's response. On all items except the eighth through the twelfth, a "6" response equals a score of 6, a "5" equals a score of 5, a "4" equals a score of 4, a "0" equals a score of 3, a "3" equals a score of 2, a "2" equals a score of 1, and a "1" equals a score of 0. With the eighth through the twelfth items, which are stated in negative terms, a "6" response equals a score of 0, a "5" equals a score of 1, a "4" equals 2, a "0" equals 3, a "3" equals 4, a "2" response equals 5, and a "1" response equals 6. The highest possible score on each dimension is 24 and the lowest possible score is 0.

Advisory Council role perception
questionnaire.

THE ROLE OF A COUNCIL MEMBER

(What Do You Think?..)

Please read each statement and circle the response to the right that indicates your level of agreement or disagreement with that statement in relation to your role as a Council member.

	Strongly SA=Agree	A=Agree	?=Uncertain	D=Disagree	Strongly SD=Disagree
Attend all Council meetings	SA	A	?	D	SD
Attend all Task Force meetings	SA	A	?	D	SD
Read mailed information prior to Council meetings	SA	A	?	D	SD
Speak up at meetings	SA	A	?	D	SD
Help others to speak up at Council meetings	SA	A	?	D	SD
Make sure that you always understand what's under discussion at Council meetings	SA	A	?	D	SD
Submit agenda items for Council meetings	SA	A	?	D	SD
Submit agenda items for your Task Force meetings	SA	A	?	D	SD
Learn as much as you can about your Task Force's area	SA	A	?	D	SD
Get information for your Task Force	SA	A	?	D	SD
Write drafts of position papers	SA	A	?	D	SD
Offer resources of your own organization or community group (e.g. physical facilities, printing, staff, materials, etc.)	SA	A	?	D	SD
Meeting with others outside Council to solicit opinions, reactions, ideas, etc.	SA	A	?	D	SD
Inform others about the work of the Council	SA	A	?	D	SD
Lobbying to support Council recommendations	SA	A	?	D	SD

FORMAT FOR INTERVIEWS WITH COUNCIL MEMBERS

Suggested Introduction

As you know, I am one of four people who are interviewing all members of the Health Planning Advisory Council. The purpose of these interviews with council members is to learn as much as possible about what the experience of being a council member has been like over this past year. We're interested in discovering what the year's experience on the council has looked like through the eyes of each council member. If we can find this out, then this information should help the staff of the Office of Health & Medical Affairs and the total council gain a rich understanding of how things went this year with the council and what efforts need to be provided next year in order to make the council as effective as it can be as an organization and as fulfilling an experience as it can be for each member. So, that is why these interviews are being conducted. Before moving ahead with the interview, do you have any questions about the purpose of it?

Different council members may have different feelings about being interviewed. How does this set with you; is this perfectly O.K. or do you have any reservations?

Let me say something about the nature of the interview. I have some areas that I'd like to help us cover, but I don't have a series of specific questions to ask. What I would like to do is just to initiate conversation that hopefully will assist you to think back over your year's experience. There may be some things that you will mention that I'd like to gain a fuller understanding of and, at those times - if you don't mind, I'd like to ask if you can say something further about that. If I should do that and you've said all you want to say at that point, please just tell me so. Once again, I'd like to emphasize that I'd like to get us to focus on just your experience on the council over this past year - from last May 'til now. Any questions, before moving ahead?

One other thing. I'd like to be able to just sit and converse and hear everything you say rather than try to write everything down. Is it O.K. if I use a tape recorder - that surely will help me if it won't hinder you.

We want to assure you that this interview is strictly confidential. The four interviewers will be the only persons listening to the tapes and no names or identifying information will be recorded from the tapes. As soon as the tapes have been analyzed they will be destroyed.

May we begin?

Schedule of Questions

- 1.) How do you see yourself operating in the council? - - -
As an individual representing yourself, as an individual representing a group, or as an advocate of a very particular issue. (If either of the latter two) Which group or issue ... what is the size of the group?.

- 2.) Were you a consumer or provider member of the council? Did this have any implications for the way you participated on the council? (If clarification is needed) Did this influence or affect what you said and did as a council member?

- 3.) During the year, you were faced with a great deal of information; in both written and orally presented form, about health, health systems, and health planning. (Hand person card and review categories as follows)

Information that confirmed or reinforced things you already knew

Information that corrected what you previously thought was true

Information that gave you a new perspective on things

Information that was brand new to you

There may have been information that confirmed or reinforced things you already knew, information that corrected what you felt you previously thought was true, information that somehow gave you a new perspective on things, or information that was brand new to you. Please tell me what you recall under these areas.

(After all telling has occurred, ask person to rank the four areas as to how much each occurred for them.)

- 4.) (Hand person card of steps in the health planning process.)

Do an exploration of the problem
Gather and review relevant studies
& data
Determine priority problems or issues
Do an exploration of solutions
Use experts and available resources
Draft preliminary recommendations
Get review & reaction by critical groups
Draft final recommendation, including
who is responsible for what action
Provide for evaluation of effectiveness
of services

Do you recall having received information about these steps of the health planning process?

To what extent did your Task Force actually use these steps in its work?

To what extent were these steps helpful in the work of the Task Force?

- 5.) I would like to find out how you experienced the many different people on the council. At the first couple of meetings you attended, how many members did you know, how did you feel toward them, how did you feel toward the others you did not know.

Did any of this change for you over the year? (If yes - ask person to state what changed).

What occurred that helped bring about this change?

- 6.) I would like to find out how you experienced the council as a group. What was it like during the first couple of meetings you came to - regarding such things as the way the council made decisions, the atmosphere or climate, ability to work together as a group, sense of involvement, etc.

Did any of this change over the year? (If yes - ask person to state what things changed).

What occurred that helped bring about these changes?

- 7.) Task Force (Use same format and order as for Council)

- 8.) Task Force members (Use same format and order as for Council members)

- 9.) I'd like to ask you about your views of the staff. Regarding the two persons¹ that worked with your Task Force, at the beginning how well did you feel you knew them? How helpful or unhelpful do you feel they were?

Did this change?

What brought about the change?

¹ Task Forces:	<u>Medicaid</u>	<u>Maternal & Child Health</u>	<u>Cost Containmt.</u>
Staff person:	Carol Hesselbacher	Bob Yellen	Jim Bernthal
Primary consultant:	Eugene Feingold	Ruben Meyer	Paul Ginsberg

(Do same as above for Council, in reference to total OHMA staff² without naming any of staff except in response to a question.)

²Office of Health & Medical Affairs Staff:

Donald Smith, Director
Jay Endsley, Asst. Director
Kurt Gorwitz, Asst. Director
Dick Schmidt, Asst. Director
Janet Coye, Project Director

Tom Jones, Asst. to Director
Sherry Cunningham, Secretary -
court-records council sessions
Shirley Benjamin, Secretary -
Hands out materials at door at
start of meetings

- 10.) Lastly, and this may, at first hearing, sound a little strange -
in what ways did your experiences with the council affect you
as a person - what did the experience do to or for you? Before
you answer, I'd like to be sure I'm coming through clearly.
Is the question I'm asking perfectly clear?
(Press hard, if necessary, for any influence on self or social
perceptions, perspectives, attitudes, feelings, awarenesses,
sensitivities, skills, ways of thinking, etc.)

APPENDIX C

SAMPLE PROJECT MATERIALS

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MEMORANDUM

State of Michigan
EXECUTIVE OFFICE

Office of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-7688

To: Members of the State Health
Planning Advisory Council

Date: 9/13/73

From: Janet Coyle
Associate Project Director

Subject: Council Development Project - 314(c) Grant

As you know, the Office of Health and Medical Affairs has received a grant which gives the Council the opportunity to gain new knowledge about comprehensive health planning processes and methodologies. This will be done as state policy recommendations are determined in three areas: Maternal and Child Health, Medicaid and Health Cost Containment. These three Task Forces already established by the Council have each met at least once.

In order to set the stage for the coming months of Task Force and Advisory Council effort, would you please consider the attached material. It is intended as a guide for the work of each Task Force. If you have questions or comments please call me as soon as possible at 517/373-0100; I would like to know of your reaction to this preliminary outline of what we are to do.

JC:km

GENERAL GUIDELINES FOR THE HEALTH PLANNING PROCESS,
TO BE MODIFIED AS NECESSARY BY EACH TASK FORCE

MATERNAL AND CHILD HEALTH TASK FORCE
MEDICAID TASK FORCE
HEALTH COST CONTAINMENT TASK FORCE

Introduction

The final documents produced as a result of these three Task Force efforts will describe and analyze the State's current and projected health needs and resources in each area of concern and recommend necessary changes. They will include recommended state health goals and state health policies and will make specific recommendations for action based on these goals and policies. Activities required to implement recommendations, and those responsible for such activities, will be identified.

The result should be flexible, revisable, public documents each of which considers a range of factors that influence the area of concern of that Task Force. Because of specific limits placed on the time and labor available for the work of each Task Force both the scope and depth of the effort must be limited. Ranking goals in priority order can enable each Task Force to concentrate on those items it considers to be most important and appropriate within the known time and labor restrictions. Goals not chosen for this effort either because they were deemed not as important or because they could not appropriately be considered by this group at this time should be identified in each document as guides for future state health planning.

Previous work done by others in each Task Force area of concern must be considered and will modify the way in which the preliminary steps in the planning process as outlined here are used, e.g., the perinatal intensive care plan from the State of Maine has been used by the Maternal and Child Health Task

Force in preparing a position paper.

Steps in the Health Planning Process

Identify needs
Inventory resources
Establish goals
Determine priorities
Analyze resources
Project future needs
Develop objectives
Analyze alternatives
Choose most feasible alternative
Identify implementation responsibilities
Provide for evaluation

Identify needs What are the problems? Who is affected? Statistical information and data on the concern of the public (both provider and consumer) should be assembled.

Using Emergency Medical Services (EMS) as a hypothetical example, problems include lack of adequate emergency care and transportation in some areas of the State, uneven distribution of EMS in hospitals, need for adequate communication between vehicles and hospitals, etc. Data on who is affected by these problems and the extent of concern in solving them are gathered.

Inventory resources What are the existing and planned programs for handling these problems? Are they successful? Where are they, who is involved, how are these programs financed? What other resources do we have for helping with these problems?

Continuing the EMS example, information on existing programs for updating EMS and an inventory of vehicles, equipment, personnel, financing and emergency rooms is necessary. Other resources (helicopters, training of para-medical personnel, federal financing) and ideas (a classification system for hospitals to reflect the level of EMS available at each hospital) are explored.

Establish goals The desired conditions of the health of people and the directions toward which the health system or related systems should move should be identified by each Task Force for its area of concern.

The general goals for EMS might be that adequate emergency medical services be available to every resident of Michigan. More specific goals might include statements relating to the classification of hospital emergency services, distribution of emergency services, response time, equipment, training, financial accessibility of such services, etc.

Determine priorities Rank and then choose priority goals to be worked on by this Task Force now. What can and should a State do? What can be done on a State level? Remember that the Advisory Council will make recommendations concerning both governmental and nongovernmental decision-makers.

In EMS a high priority but time limited goal might be the classification of hospital and emergency services in order that everyone can easily determine the level of EMS available at each hospital in the State.

Analyze resources Examine the extent of resources, accessibility, costs, use, overlaps and gaps as they pertain to each priority chosen. Existing studies in Michigan and elsewhere should be used. How are other States coping with these problems?

In order to classify hospital emergency services, possible resources to determine EMS levels in hospitals, the need for legislation, the cost of such a program, how it is being done elsewhere, etc., are examined. This would include the involvement of the MESH Council, the Michigan Department of Public Health, the Michigan Hospital Association, etc.

Project future needs Forecasts of various system measures should provide an estimate of future demands if no changes are made. Comparison with desired conditions or accepted standards provides a basis for recommendations to bridge gaps.

The EMS example chosen is only indirectly applicable here. A classification system would aid in projections for training programs, additional facilities, etc.

Develop Objectives Clearly stated objectives should be determined. Derived from goals, they should express a partial attainment of goals. They should contain results to be achieved within a specified period of time with specified resources.

Analyze alternatives What are the alternative means to accomplish the stated objectives? What are the advantages and disadvantages of each? Financial, technical and political feasibility should be considered.

The objective of classification of hospital emergency services might be accomplished by legislation empowering the Department of Public Health to establish such a classification system and to adopt such rules and regulations required to assure that the level and quality of EMS actually delivered are consistent with a hospital's classification. Other means including involvement of the Michigan Hospital Association, the areawide comprehensive health planning agencies, etc., are explored.

Choose most feasible alternative Each Task Force should choose the alternative actions most likely to accomplish the stated objectives. Tentative recommendations are discussed with key groups, both those who will be affected by the recommended actions and those responsible for implementation. Recommendations for action, including identification of actors, should then be developed.

Identify implementation responsibilities The Advisory Council is not responsible for the operation of health programs, nor for the decision-making process that directly allocates State resources. However, in addition to making recommendations to decision-makers, it can influence implementation of its recommendations in a variety of ways. Each Task Force should identify the means by which the Task Force and the Advisory Council can assist the implementation of its recommendations. For example:

1. Take positions on pertinent issues of statewide concern, and bring these to the attention of the public.
2. Make decisions in the review of programs and projects which minimize uneconomic duplication of health facilities and services and foster productivity and efficiency in the health system.
3. Involve affected parties in the planning process.
4. Cooperate in planning done by others.
5. Assist implementing bodies with educational, technical and planning activities.

Provide for evaluation Each Task Force should plan for evaluation and future revision and/or expansion of its work. When and how will an assessment be made of the accomplishment of objectives and their effect in reaching goals?

TASK FORCE WORK PROGRAM METHOD

Introduction

This section of the report briefly summarizes the sequential steps which are being followed by the Task Forces in carrying out their mission to 1) identify and understand strategic problems, 2) develop appropriate and innovative policy recommendations and 3) facilitate the implementation of those recommendations.

The Task Forces are using a program planning model as an overall guide to their efforts. This strategy provides an orderly process for the structuring of decision-making at different phases of the work. By applying this strategy, the Task Forces are providing an opportunity for citizens as consumers, health professionals, representatives of health and health-related organizations and agencies, members of government, and scientific and academic and resource people to participate at appropriate and critical points in the development of recommendations. Such a planning situation obviously requires guidelines for the identification and incorporation of these differing viewpoints, and the model provides these guidelines.

Program planning and development are divided into three phases applicable to the work of the Task Forces:

Phase I: Problem Exploration

Phase II: Knowledge and Solution Exploration

Phase III: Preparation of Recommendations and Report

Phase I: Problem Exploration

The essential steps in Phase I are as follows:

1. The identification of broad problem categories.
2. The formation of Task Forces responsible for specific study in each problem category, specific study to be done by means of:
 - a. Further problem-exploration contact with target groups having detailed information about a particular problem, including consumers, providers, existing organizations, interest groups and government agencies.
 - b. The review and gathering of related studies and data.
3. The determination of priority problems within the broad problem categories, which are the central focal effort of the Task Forces in Phases II and III.

Step 1: The Identification of Broad Problem Categories

Governor Milliken, in a letter dated April 19, 1973, to Dr. Robert Kinsinger as Acting Chairman of the State Health Planning Advisory Council, asked that the Council give major attention to three specific, substantive areas in the coming year. He requested development of a state policy on the extension and improvement of health services to mothers and children, recommendations concerning the future development of the Medicaid program and development of measures directed toward cost containment in the health care field.

Simultaneously, the state comprehensive health planning agency applied for and was awarded a 314(c) grant for Advisory Council education and development. The grant proposed using the process of policy development in the three substantive areas as the vehicle for the further development of the Council's policy-making capability.

Step 2: Formation of Task Forces and Further Problem Identification

At the July 18, 1973 meeting of the Advisory Council three Task Forces were established: Maternal and Child Health, Medicaid and Health Cost Containment. Each Task Force has continued the problem identification step by identifying all relevant issues or problems within its area of concern. Further information was sought where necessary by identifying specific reference groups who provided further detailed information about problem sub-categories. In some cases, further meetings or other contact with consumers, providers, existing organizations, interest groups, and government representatives was necessary to obtain greater detail concerning some problem areas identified in a global manner. Further, careful study of state and regional data relating to the problem categories was begun.

Step 3: Determination of Priority Problem Categories

Phase I ended with the determination of priority problems to be the focal effort for the Task Forces for the remainder of their work program.

The major areas given highest priority by the Task Forces for intensive knowledge and solution exploration are listed in the Task Force progress reports within this report and the actual process by which these were determined by each Task Force is described.

A central guideline to the conclusion of the Phase I endeavor was the ability of the Task Forces to answer the following two questions:

1. What are the major priority problems that should provide the focal point for further effort by the Task Force?
2. Do we know enough about the character of these priority problems to proceed to search for possible solutions?

Phase II: Knowledge and Solution Exploration

The purpose of Phase I is to be sure that the efforts of the three Task Forces are directed to the priority problems of the State of Michigan in these three areas. The primary purpose of Phase II is to assure that the very latest scientific and professional insight is tapped in seeking solutions to these priority problems and to formulate preliminary recommendations.

The essential steps in Phase II are as follows:

1. The identification of multi-disciplinary skills relating to each priority problem.
2. The identification of and contact with resource people who have insight with respect to each priority problem.
3. A search for existing literature and data relating to the problem categories, including what is happening in other states, and the development of background information.
4. Solution exploration meetings making use of Council members, outside resource people, consumers and relevant professionals.
5. The determination of cost and technical requirements for each major recommended solution.
6. The preparation of preliminary recommendations to be reviewed in Phase III.

Steps 1 and 2: The Identification of Needed Skills and Key Resource People

The identification of multi-disciplinary skills relating to each priority problem is the operational step by which each Task Force seeks to deal with the realities underlying the terms "interdisciplinary," "multi-disciplinary," and "information explosion." Clearly, any problem sub-category defined by a Task Force as a priority will relate to a variety of existent organizations and a variety of existent disciplines. (For example, the critical issues in consumer education in health relate to health professionals, educationists, mass media specialists, sociologists familiar with the nature of attitude change, professionals working with critical population subgroups such as minority or ethnic groups, representatives of consumer groups, etc.) The intent of the first two steps in Phase II is to make sure that the insight of these various resource people is tapped. This involves 1) identifying related groups and skills, 2) contacting agencies and professionals to obtain nominations of resource people who might be helpful, 3) follow-up contact with these potential resource people, and 4) summarizing the insights obtained from these resource people. It is the intent of the Phase II strategy that the best

thinking available (not simply within the state but in the nation) across a variety of disciplines, be brought to bear on the development of appropriate solutions.

Step 3: Surveying the Literature

In addition to resource individuals, however, there already exists a body of literature and existing data relating to many priority problems. A search strategy for extracting this literature from a variety of professional journals and organizational publications is also necessary.

Step 4: Solution Exploration

After a fairly complete search for existing knowledge, the actual difficult work of preparing recommendations still remains. For this purpose, meetings which combine the insights of various resource people, Task Force and other Advisory Council members, professional representatives, and opinion leaders among health agencies and institutions are conducted. The purpose of this meeting or series of meetings is to generate a list of possible solutions, to rank order alternative solutions and their components and to formulate possible policy recommendations.

Step 5: Determination of Cost and Technical Requirements

It is not the intention of the Task Forces, however, simply to recommend broad solutions. Some initial exploration into the technical requirements of recommended policies, the feasibility of implementing such policies, existing resources to implement such policies, and the general cost of recommended policies is also part of the Task Force responsibility. In those instances where reallocation of resources or development of programs are to be recommended, the gross technical requirements and costs must be explored by the Task Force.

Step 6: Preparation of Preliminary Recommendations

Phase II is complete when each Task Force has developed a list of preliminary policy recommendations. These are based on possible solutions for each major priority problem, an assessment of alternative solutions, and the gross technical requirements for the recommended alternatives.

Phase III: Recommendations and Report

Phase III is concerned with review and modification of the preliminary recommendations, the formulation of final recommendations and the preparation of the final report.

The general logic of Phase III is that some discussion and preliminary acceptance of the critical features of Task Force preliminary recommendations should take place prior to the submission of final recommendations.

Critical steps in Phase III are the following:

1. A review and coordination of preliminary recommendations with those of other Task Forces and other previous or anticipated actions by the Advisory Council.
2. An informal review of the preliminary recommendations of each Task Force by the Advisory Council, opinion leaders, consumers, providers, government representatives, agencies administrators, and resource controllers.
3. The obtaining of more-or-less formal endorsements of the recommendations of the Task Forces from these constituent groups.
4. The preparation of the final formal Task Force recommendations and report.
5. Review and action by the Advisory Council.

Step 1: Coordination of Preliminary Recommendations

It is necessary to synthesize the recommendations of the individual Task Forces whenever possible. This may require modification of some recommendations or preparing joint recommendations coming from two or more Task Forces.

Steps 2 and 3: Informal Review and Reaction by Critical Groups

Once the preliminary recommendations have been established the suggested solution strategies need to be reviewed by those groups which will be affected. This preliminary review must take place prior to the dissolution of the Task Forces since much of the knowledge, legitimation, and support for the recommendations will be less available after the Task Forces complete their work. The general spirit of this informal review, therefore, is to bring together clients, providers, administrators, experts, government representatives and others who will be affected by or must relate to a specific set of recommendations. (For example, recommendations in the area of consumer education ought to be reviewed by those agencies who might eventually be charged with detailed program planning for education, by those citizens who will be the object of this education, by those professionals who are most centrally interested in the content of the educational message, and by those members of government or controllers of resources who will have to allocate or reallocate resources in support of a particular type of educational program.) It is the intent of Phase III that these reviews take place and that, where possible, formal endorsements by these important constituencies be obtained prior to the summation of the final reports of the Task Forces. This also implies that the recommendations of the Task Forces are open to modification or adjustment at this review point. The Advisory Council participates as one group in this review process, which provides an opportunity for all Council members to influence the recommendations before they are presented to the Council for action.

Step 4: The Final Report

The final report should contain:

1. The identification of priority problems, with sufficient background information.
2. The identification of alternative solutions, discussed in terms of importance and technical feasibility.
3. Task Force recommendations together with endorsement of these recommendations by critical agencies eventually involved in implementation and including adequate supporting information.
4. A fairly detailed outline of the essential steps -- including who is responsible for what actions -- which will have to be followed in the period subsequent to the dissolution of the Task Forces in order to achieve the successful implementation of the recommendations.
5. Some guidelines in terms of a reasonable time frame, costs, and organizational arrangements that will be necessary for implementation.
6. A plan for future Advisory Council evaluation of the effectiveness of the implementation of resulting state health policy.

Step 5: Review and Action by the Advisory Council

The final recommendations and report of the Task Forces are then presented to the Advisory Council for consideration, modification and acceptance.

MEMORANDUM

State of Michigan
EXECUTIVE OFFICE

Office of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-7688

To: Members of the State Health Planning
Advisory Council

Date: 10/30/73

From: Janet L. Coyle
Associate Project Director

Subject: The following description of state comprehensive health planning was drawn from material prepared for a September 1973 meeting of state health agency directors. It has been prepared for your information and for purposes of discussion.

The mission, or basic purposes, of comprehensive health planning at the state level involves:

- a) analysis and formulation of health policy for decision-makers at the state level.
- b) promotion, coordination and integration of areawide health planning within the state in such a manner that both state and areawide needs and objectives are met, and quality of the planning efforts is continuously up-graded through provision of technical assistance
- c) accomplishment of assigned state and federal legal responsibilities particularly in the areas of cost-containment, facilities review, and other authorized roles of 314(a) agencies
- d) development of a comprehensive statewide plan for health that incorporates all appropriate health concerns of state government regarding: interagency coordination; areawide and local needs; an adequate data system to support ongoing planning responsibilities at state and areawide levels; appropriate allocation of state resources, private as well as public, in the health care system; recommendation of new approaches to the provisions of health care services, cost-containment, and maintenance or improvement of quality of care; identification and application of state goals and priorities in development of recommendations regarding health manpower, community services, family and personal health, health care facilities, financing, environmental and mental health concerns.
- e) preparation of such studies and analyses as are necessary in carrying out any of the above purposes, in reviewing federal grant applications, and in assisting in the development of specialized health planning capability in a variety of subfields identified in federal and state legislations.
- f) promotion of the basic principles of comprehensive health planning including: partnership between public and private sector; local needs identification and priority setting; consumer involvement and representation of all segments of the affected population as well as all provider interests; close working relationships with governmental officials and related planning agencies; promotion of public awareness of health needs, issues and planning capabilities and activities through public information programs at the state and area-

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wide level; promoting appropriate staff and volunteer roles at both the areawide and state levels; moving the state comprehensive health plan toward implementation through mobilization of widespread public support, legislative backing, and advisory council leadership, as well as through the exercise of persuasion in the executive branch of government and the aggregated influence of the areawide health planning councils.

CHRONOLOGICAL CHART OF MAJOR ACTIVITIES -- 314(c) GRANT

May 1973 through June 1974			Activities Related to Both Policy Objectives and Educational Objectives	
Contact	Date	Task Force and Council Activities Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	
Advisory Council Meeting	May 9, 1973	A. Informed of the Governor's request to the Council for FY 1973-74: 1) develop state policy on the extension and improvement of health services to mothers and children; 2) make recommendations concerning the future of the Medicaid program; 3) develop measures directed toward cost containment in the health care field. B. A form was distributed which enabled members to choose one task force on which to work.	A. Informed of the 314(c) grant application. B. Filled out the meeting evaluation questionnaire developed by the person who became educational consultant. (Menlo)	
Advisory Council Meeting	July 18, 1973	A. Membership in each of the 3 task forces announced. B. Informed of the awarding of the 314(c) grant and its support of staff and consultants for task force work.	A. Informed of the education and development intent of the 314(c) grant. B. Reviewed May 9 Council meeting. C. Filled out meeting evaluation questionnaire.	A. Briefing on background and issues in perinatal intensive care by resource person (Rice).
Maternal and Child Health Task Force Meeting	July 18, 1973	A. Consideration of overall objectives and task force work program. B. Consideration of request for state policy recommendations on perinatal intensive care by September Council meeting and decision to proceed.		A. Discussion of the budgetary and political processes as they affect PIC policy development.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Medical Task Force Meeting	July 18, 1973	A. Consideration of the request by the Governor. B. Decision to obtain views and opinions of consumer and provider groups regarding problems via letters rather than public hearings.		
Health Cost Containment Task Force Meeting	July 18, 1973	A. Consideration of objectives and possible accomplishments of task force work program. B. Decision to have August task force meeting to further explore issues.		
Maternal and Child Health Task Force Staff and Educational Consultant	August 13, 1973		A. Designed aspects of Maternal and Child Health Task Force meeting.	
Maternal and Child Health Task Force Meeting	August 15, 1973	A. Discussion of task force's scope vis a vis perinatal intensive care issue.		A. Discussion of perinatal intensive care issues. B. Discussion of data needs.
Health Cost Containment Task Force Meeting	August 15, 1973	A. Consideration of major factors in increasing costs. B. Discussion of problems task force should examine and what it hopes to accomplish. C. Decision to send questionnaire to task force members on health cost containment issues.		A. Identification and review of background materials. B. Discussion with 2 resource people. (Vaughn, Serafin)
Maternal and Child Health Task Force Meeting	September 5, 1973	A. Review and modification of draft of report on perinatal intensive care. B. Development of recommendations.		

Context	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Mailed to Advisory Council Members	September 10, 1973		A. General Guidelines for the Health Planning Process.	
Grant Staff and Educational Consultant	September 11, 1973		A. Discussion of how to approach educational component and alternative means to reach objectives.	
Staff and Educational Consultant	September 17, 1973		A. Designed September 20 Council meeting.	
Maternal and Child Health Task Force Meeting	September 20, 1973	A. Review of final draft of Policy Statement: Perinatal Intensive Care in Michigan. B. Modification of recommendations on perinatal intensive care. C. Discussion of other issues to be considered.	A. Filled out task force meeting evaluation questionnaire.	
Medicaid Task Force Meeting	September 20, 1973	A. Discussion of issues and problems concerning the Medicaid program. B. Draft letter to provider and consumer groups read. Recommendations made on groups and individuals to receive the letter.	A. Review of General Guidelines for the Health Planning Process.	A. Presentation on current status and problems of Medicaid program by 2 resource people and primary consultant. (Paterson, Lindsey, Feingold)
Health Cost Containment Task Force Meeting	September 20, 1973	A. Discussion of responses to task force questionnaire on health cost containment issues.	A. Review of General Guidelines for the Health Planning Process. B. Filled out task force meeting evaluation questionnaire.	A. Presentation summarizing Rising Medical Costs in Michigan by senior author (Stuart) B. Discussion of information needed.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Advisory Council Meeting	September 20, 1973	A. Considered Policy Statement: Perinatal Intensive Care in Michigan and voted to accept report and endorse recommendations.	A. Use of a procedure to facilitate discussion and vote on recommendations. ("Yes, No, ?" sheet) B. Review of July meeting evaluation. C. Filled out Council meeting evaluation questionnaire.	A. Question and answer session on perinatal intensive care led by task force chairman and resource person. (Tobin, Rice)
Grant Staff and Educational Consultant	October 12, 1973		A. Discussion of the use of Advisory Council and Task Force Inventories and a questionnaire on role of Council members.	
Grant Staff and three Consultants (CHSER)	October 19, 1973			A. Brainstorming Session to supplement problem exploration by HCC and Medicaid Task Forces and to generate all possible key groups and individuals for possible contact.
Medicaid Task Force Meeting	October 22, 1973	A. Response to letter to consumer and provider groups categorized and reviewed. B. Three priority areas determined.	A. Filled out task force meeting evaluation questionnaire. B. Worksheet mailed in advance to help focus individual concerns.	A. Presentation on provider attitudes toward Medicaid by resource person. (Fryfogle) B. Three general areas determined for further study. C. Decision reached on data needed. D. Decision to present Medicaid issues at November Council meeting.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Health Cost Containment Task Force Meeting	October 24, 1973	A. Discussion of Hospital Finance Authority Act and the reorganization of state departments of public health, mental health and social services. B. Further refinement of list of priority issues.	A. Health Cost Containment follow-up questionnaire mailed previously to task force with focus of discussion of priorities. B. Discussion of other issues in health care delivery system with implications for cost containment by resource person. (Stevens)	A. Presentation and discussion of major policy areas for health cost containment and their organization by primary consultant. (Ginsburg) B. Decision reached on need for definition of terms. C. Presentation and discussion of concepts in a computer model simulation of cost containment by resource person. (Nunn) D. Discussion of data bases needed for decision making.
Grant Staff Meeting (in lieu of task force because of September deadline for perinatal intensive care report)	October 25, 1973			A. Identification of implementation responsibilities regarding perinatal intensive care recommendations. B. Discussion of possible future evaluation of implementation of perinatal intensive care recommendations.
Staff and Educational Consultant	October 26, 1973		A. Designed November 13 Council meeting.	
Maternal and Child Health Task Force Meeting	October 30, 1973	A. Report on progress of Perinatal Intensive Care Policy Statement. B. Discussion of the work of another group on quality assurance of abortion services. C. Discussion of maternal and child health issues and solicitation of individual priorities.	A. Report on how maternal and child health policy will relate to a comprehensive state health plan. B. Discussion of health planning process in relation to development of a policy statement on maternal and child health.	A. Decision on format for presentation of maternal and child health issues at November Council meeting.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Advisory Council Meeting	November 13, 1973		A. Definition of state comprehensive health planning distributed. B. Educational Consultant (Menlo) discussed educational objectives and selected testing and evaluation techniques. C. Associate Project Director (Coye) discussed task force work program method—three phase program planning model.	A. Chairman (Hunt) announced the Governor's endorsement of the Policy Statement: <u>Perinatal Intensive Care in Michigan</u>. B. Maternal and Child Health Task Force discussion. Introduction by primary consultant (Meyer). Seven groups formed to discuss specific MCH issues. C. Medicaid Task Force discussion. Primary consultant (Feingold) and resource person (Paterson) discussed background to Medicaid and general areas of task force priority consideration.
Medicaid Task Force Meeting	November 13, 1973	A. Received scaled rating of Michigan Medicaid program by coverage, benefits and per capita outlay. B. Received listing of specifically requested benefits for HMO, vision, dental and home health care. C. Received poverty estimates and statistics on Medicaid coverage.		A. Finalized coverage objectives by determining task force attitudes.
Health Cost Containment Task Force Meeting	November 13, 1973	A. Discussion of Hospital Finance Authority Act and its relationship to Certificate of Need legislation and cost containment. B. Document discussed: <u>Summary of Primary Consultant's Remarks re Policy Alternatives</u>.		A. Presented document: <u>Organization of Health Cost Containment Priorities</u>. B. Discussion of the costs of medical education as a cost containment issue.
Grant Staff Report	November 15, 1973			A. Personal contact, via individual interviews, with each task force member by task force staff persons approx. 1/2 completed.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Mailed to Advisory Council Members	November 16, 1973		A. Human Development Inventory on Council and Task Force membership. B. Role assessment as Council member.	
Grant Staff and Educational Consultant	November 27, 1973		A. Discussion of possible testing of Advisory Council members on health planning concepts and Task Force subject areas.	
Maternal and Child Health Task Force Meeting	November 28, 1973	A. Priority issues established and rank-ordered.	A. Discussion of November 13 Advisory Council meeting and MCH discussion groups as educational experiences.	A. Discussion of political feasibility of success regarding priority issues.
Meeting of OHMA Staff and Areawide Health Planning Agency Directors	November 29, 1973			A. Discussion of Task Force progress and possible area-wide health planning agency involvement.
Maternal and Child Health Task Force Meeting	December 12, 1973	A. Further refinement of top-priority areas to be considered.	A. Discussion of various measures of health status which can be used.	A. Discussion of a "philosophy of maternal and child health". B. Presentation of a draft outline for use in describing health status of mothers and children and services currently available.
Meeting of Grant Staff and Assistant Director	December 13, 1973		A. Integration of 314(c) grant objectives with Council involvement in agency assessment and planning for a state health plan.	

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Mailed to Advisory Council Members	December 14, 1973			A. State Health Planning Agency Performance Standards.
Health Cost Containment Conference attended by Task Force Chairman, and Staff, OEA Planning and Research Staff, Grant Staff, External Consultants	December 19, 1973	A. External consultants discussed and ranked problem areas and formulated recommendations for the Task Force.	A. Discussed health care data and data needs, and the generation of meaningful policy recommendations given the state of the art of health data.	A. Discussed a proposal submitted by the National Sanitation Foundation regarding the application of computer simulation methodology to the work of the Task Force. B. Decided to reject the proposal.
Grant Staff and Educational Consultant	December 20, 1973		A. Report and discussion on response to 3 questionnaires. B. Decision made not to test Advisory Council on knowledge of three Task Force areas and health planning. C. Planned future use of post-meeting evaluation forms. D. Discussion of strategies for more involvement of Task Force members.	
Medicaid Task Force Meeting	January 3, 1974	A. Set general tone of final report and established primary objective of Task Force's work.	A. Education in selection of alternatives given certain political realities, choice between "ideal program" report and subject-specific report.	Sent materials: A. Home Health Services for the Aged in Southeastern Michigan. B. Compilation of problem areas and related political and economic factors compiled by staff.
Advisory Council Executive Committee Meeting	January 4, 1974		A. Presentation and discussion of response to Advisory Council questionnaires.	

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Advisory Council Executive Committee Meeting (continued)			B. Discussion of workshop to be held for Advisory Council members the evening before the February Advisory Council meeting on State Health Planning Performance Standards, assessment and the state health plan.	
Health Cost Containment Meeting attended by Task Force Chairman, Staff Planner, External Consultant, Wage and Price Control Administrator	January 10, 1974	A. Discussed the value of Wage and Price Control as a cost containment mechanism.	A. Further education of chairman regarding alternatives to present cost reimbursement mechanisms.	A. Established communications with the Wage and Price administrator regarding the work of the Task Force.
Staff and Educational Consultant	January 18, 1974		A. Designed January 24 Advisory Council meeting.	
Health Cost Containment Meeting attended by Task Force members, Staff, Consultants, and Guests from the Greater Detroit Area Hospital Council	January 22, 1974	A. Decision to make policy recommendations regarding the prospective reimbursement of hospitals as a means of containing cost influencing variables.	A. Discussion of progress as a Task Force working through the problem-solving method.	A. Defined resources skills and information needed through analysis of prospective reimbursement. This included: (1) developing a framework for examining different approaches, (2) identifying area of performance that might be affected by prospective reimbursement, (3) analyzing the changes in hospital performance predicted by different approaches to prospective reimbursement and (4) proposing alternative methods for setting budgets or rates prospectively.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Maternal and Child Health Task Force Meeting	January 23, 1974	A. Presentation of data gathered on current health status of mothers and children in Michigan.		A. Discussion of current funding mechanisms for public MCH programs. B. Discussion of work being done by consultants to gather information about MCH policy and program development in other selected states.
Advisory Council Meeting	January 24, 1974		A. Discussion of the analysis of responses to the 3 questionnaires: Advisory Council and Task Force inventories and the role of a Council member. B. Presentation and discussion of changes resulting from information received from meeting evaluation questionnaires. C. Filled out meeting evaluation questionnaire.	A. Reports by each chairperson on Task Force progress.
Mailed to Task Force Chairpersons and Consultants	January 30, 1974			A. 314(c) Grant Interim Report.
Mailed to Advisory Council Members	February 1, 1974			A. Questionnaire to determine Advisory Council opinion on definition of responsibilities for development of a state health plan.
Mailing to Area-wide CHP Agencies	January & February 8, 1974			A. Letters from each Task Force staff planner asking for participation in identifying resources, providing information,

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
				review of preliminary recommendations, etc.
HCC Staff Planner Organized and Met With Technical Work Group	February 14, 1974		A. Developed a group of persons in Michigan with expertise in the area of prospective reimbursement.	A. Began to identify the component parts of the prospective reimbursement problem and their relationships in order to develop a framework for understanding alternative programs and writing recommendations.
Meeting of Staff and Educational Consultant	February 8 & 15, 1974		A. Planned February 20 Workshop.	
Meeting of Staff, Educational Consultant and Chairman	February 15, 1974		A. Designed February 21 Advisory Council meeting.	
Advisory Council - Staff Workshop	February 20, 1974			A. Workshop (dinner and work sessions) on "What is a state health plan?"
Advisory Council Meeting	February 21, 1974		A. Added a formal roll call to beginning of meeting. B. January meeting assessment. Discussed two page report in the February meeting folder.	A. Progress report memo on 3 Task Forces to the Governor distributed to Advisory Council members. B. Report and discussion of Workshop.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Maternal and Child Health Task Force Meeting	February 27, 1974	A. Presentation of outline of draft report and status of the Task Force in relation to outline.	A. Discussion of timetable and time constraints on planning process.	A. Discussion of the effects of categorizing mortality data. B. Discussion of value of ethnic breakdown of data. C. Discussion of outside groups to review preliminary recommendations.
Medicaid Task Force Solution-generating session on Medicaid long term care provision	February 28, 1974		A. Educational materials sent on data on nursing homes and home health agencies and on position paper on home health of APHA.	A. Persons involved in delivery of long term care throughout the state discussed problems with Task Force.
Health Cost Containment Task Force Meeting	March 4, 1974		A. Defined prospective reimbursement and described examples of prospective reimbursement programs. B. Presented the conceptual framework for the analysis of prospective reimbursement programs. C. Analyzed operating and planned prospective reimbursement programs.	A. Discussed problems and issues associated with prospective reimbursement programs.
Executive Committee Meeting	March 7, 1974		A. Results of February Advisory Council meeting assessment distributed and discussed. B. New evaluation form distributed and discussed.	A. Discussed proposed conflict of interest statement to be sent to Advisory Council. B. Reported rescheduled timetable for Task Force activities.
Grant Staff Meetings	February 22; March 8 & 11, 1974			A. Rescheduled timing of remaining Task Force activities. B. Discussed final reports, staff review of outlines and preliminary recommendations.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Meeting of Staff and 4 Consultants	March 12, 1974		A. General discussion of the educational component of the grant: objectives, assumptions, progress, possible further actions. B. Designed an "orientation and review" session for new and old Advisory Council members (April or May). C. Decided to obtain information by questionnaire from Advisory Council members on their perception of need for information (after new members are appointed).	
Meeting of Grant Staff with Director	March 12, 1974			A. Discussion of anticipated problems (internal and external) regarding final Task Force reports and recommendations. B. Decision to have a series of staff meetings on report outlines, preliminary recommendations, etc.
OHMA Staff and (c) Staff Planners	March 14, 1974			A. Planned for coordination of policy recommendations and for input of OHMA staff.
Staff Meeting to Review Medicaid Recommendations	March 19, 1974	A. Staff reviewed Medicaid preliminary recommendations for accuracy and feasibility.		

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Maternal and Child Health Task Force Meeting	March 20,			A. Discussion of major MCH resources available in Michigan. Emphasis placed on identifying geographical, economic and social barriers to health care. Began work on preliminary recommendations.
Advisory Council Meeting	March 21, 1974		A. Roll Call used again. B. Added formal approval of the agenda to the routine of the Council meeting. C. Discussion of the February meeting assessment sheets in the folder, including specific comments. D. Distributed a Glossary of Terms to Advisory Council members. E. Announced the plan to hold an orientation and overview workshop after new Council members are appointed. F. Presentation of inflationary aspects of present hospital reimbursement system. G. MCH task force primary consultant presented timetable and outline for task force work and identified major problems being considered by task force.	A. Executive Committee Report included announcement that preliminary recommendations from the three task forces will be discussed at the April meeting. B. Announced formation of an Ad Hoc Committee on State Health Plan Strategy. C. Presentation of broad guidelines for reorganizing the mechanisms of paying hospital costs. D. Chairperson reported to Advisory Council on long term care policy direction of Medicaid Task Force work.
Conference with DSS, Bureau of Research and Development (with HCC Staff Planner)	March 21, 1974	A. Discussion of HCC pre-preliminary policy recommendations.		

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Staff Meeting to Review MCH Recommendations	March 22, 1974	A. OHMA staff review of proposed preliminary recommendations.		
Meeting with Director of Health Service Plans, Michigan Insurance Bureau (HCC)	March 22, 1974	A. Discussion of pre-preliminary recommendations.		A. Discussion of Bureau of Health Insurance interest and opinions of incentive reimbursement.
Staff Meeting to Review HCC Recommendations	March 22, 1974	A. Discussion of pre-preliminary policy recommendations.	A. Discussion of technical and political issues regarding recommendations for new reimbursement system.	
Health Cost Containment Task Force Meeting	March 26, 1974	A. Discussion of pre-preliminary recommendations.	A. Discussion of lack of task force participation in policy discussion and recommendations.	A. Discussion regarding special interest group issues with new reimbursement system.
Maternal and Child Health Task Force Meeting	March 27, 1974	A. Development of preliminary recommendations.		
Incentive Reimbursement Conference: HEW, DSS, Insurance Bureau, Blue Cross Representatives	March 28, 1974	A. Discussion and critique of Health Cost Containment Task Force preliminary recommendations.	A. Discussion of HEW procedures for incentive reimbursement experiments. Major issues and preliminary results of experiments.	A. Discussion of feasibility of task force recommendations.
Staff Meeting to Review MCH Recommendations	March 28, 1974	A. OHMA staff review of preliminary recommendations with emphasis on political feasibility and wording.		

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Mailing of Medicaid Task Force Preliminary Recommendations	March 29, 1974	A. Recommendations reviewed again by staff; mailed to outside agencies for review and comments.		A. Recommendations mailed to Medicaid Task Force members for review prior to meeting.
Conference with DSS and Bureau of Research and Development (HCC)	March 29, 1974		A. Discussion of effects of federal wage-price controls on incentive reimbursement systems.	A. Discussion of task force member questions and issues regarding pre-preliminary policy recommendations.
Meetings with OHMA Staff (HCC)	March 29, April 1, 1974	A. Re-write of pre-preliminary policy recommendations.		A. Discussion of political feasibility of recommendations.
Meeting with (b) Agency Representative (HCC)	March 29, April 9, 1974	A. Presentation of preliminary recommendations.		A. Discussion of incentive reimbursement issues.
Meeting with Director of Health Service Plans, Mich. Ins. Bureau	April 2, 1974	A. Discussion of modifications of preliminary recommendations.		A. Discussion of paper "prospective Reimbursement" prepared by Insurance Bureau.
Executive Committee Meeting	April 4, 1974	A. Relationship of legislation on health insurance for newborn children to the Perinatal Intensive Care Policy Statement.	A. March Advisory Council meeting assessment discussed.	A. Discussion and consensus to take action regarding Advisory Council members with low attendance records. B. Review of memo to Advisory Council members with expiring terms asking participation in April meeting.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Meeting with House Fiscal Agency Representative (HCC)	April 5, 1974		A. Discussion of House Fiscal Agency interest in Medicaid expenditures for health care.	A. Discussion of problem of health cost containment as it relates to expenditures of personal income.
Maternal and Child Health Task Force Meeting.	April 8, 1974	A. Further refinement and additions to preliminary recommendations.		
Advisory Council Mailing	April 8, 1974			A. Preliminary recommendations from all three task forces mailed to Advisory Council members with explanation that they will be discussed and not voted on at the April Advisory Council meeting.
Meeting with Bureau of the Budget Representative (HCC)	April 10, 1974	A. Presentation and discussion of preliminary recommendations.	A. Discussion of differing effects of prospective reimbursement on hospitals and on nursing homes.	A. Discussion of experience of Michigan nursing homes with prospective reimbursement.
Meeting with Staff and Advisory Council Chairman	April 12, 1974			A. Advisory Council Planning Session. Discussion of strategy regarding presentation of preliminary recommendations.
Mailing to Medicaid Task Force	April 12, 1974		A. General background information on Michigan elderly, long term care, resources.	

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Meeting with House Fiscal Agency Representative (HCC)	April 16, 1974	A. Presentation of preliminary recommendations.		
Meeting with Bureau of the Budget Representative (HCC)	April 16, 1974		A. Discussion of issues regarding full field audits of institutional providers under different reimbursement programs.	
Medicaid Task Force Meeting	April 17, 1974	A. Reviewed preliminary recommendations.		A. Received and reviewed input from health care interest groups; revised preliminary recommendations.
Health Cost Containment Task Force Meeting	April 17, 1974	A. Modification of preliminary policy recommendations for incentive reimbursement system in Michigan.		A. Debate regarding action taken toward resolution of critical issues.
Advisory Council Meeting	April 18, 1974		A. Reviewed the assessment of the March meeting. Particular reference to the difference in consumer and provider perceptions. B. Explained the upcoming interviewing of all Advisory Council members; introduced the four interviewers.	A. Preliminary recommendations from the three task forces discussed; changes, modifications, etc., suggested to task forces.
Grant Staff Meeting with Educational Consultant and 4 Interviewers	April 24, 1974		A. Training session for interviewers, including role playing and modification of interview instrument.	

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Maternal and Child Health Task Force Meeting	April 24, 1974	A. Finalization of recommendations to be presented to Advisory Council.		A. Discussion of comments on preliminary recommendations received from outside organizations.
Medicaid Task Force Meeting	April 25, 1974			A. Reviewed recommendations and included Advisory Council suggestions from 4/18/74 Advisory Council meeting.
Interviews of All Advisory Council Members	Month of May		A. Interviews of Advisory Council members conducted as part of the grant evaluation procedure.	
Distribution to OHMA Staff	May 1, 1974		A. An outline of the grant report distributed to OHMA staff for their review and comment.	
Advisory Council Mailing	May 6, 1974		A. Worksheets mailed to Advisory Council members to aid in Advisory Council meeting deliberations.	A. Final recommendations and draft reports from all 3 task forces mailed to Advisory Council members. B. Based on information received following first draft, the report was modified and a minority report added.
Executive Committee Meeting	May 8, 1974	A. The Committee supported three state bills consistent with the Perinatal Intensive Care policy statement.		A. Discussion on strategy for handling task force reports, their discussion and voting procedures for final recommendations.

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Meeting with Staff and Advisory Council Chairman	May 9, 1974			A. Advisory Council meeting planning session. Discussion of strategy regarding task force reports and final recommendations.
Maternal and Child Health Task Force Mailing	May 10, 1974			A. Additional comments from outside groups mailed to task force members for consideration.
Advisory Council Mailing	May 13, 1974		A. Human Development Inventory on Advisory Council and task force membership and Advisory Council role assessment questionnaire mailed to Advisory Council members. (Repeat of same instruments used in Nov. 1973.)	
Advisory Council Meeting	May 16, 1974	A. Distributed to Advisory Council members a second draft of the Health Cost Containment Task Force policy recommendations and report.	A. April meeting assessment report distributed.	A. Discussion and approval of a Health Manpower project in advance of the beginning of the project. B. Advisory Council received the Maternal and Child Health and Medicaid Task Force draft reports and acted upon the final recommendations.
Grant Staff Meeting	May 17, 1974		A. Discussion and determination of 6 week timetable for final drafts of task force reports, including when they are expected to be ready to go to Governor.	

Contact	Date	Task Force and Council Work Specific to Policy Determination in 3 Areas	Educational Component Specific to Grant	Activities Related to Both Work Objectives and Educational Objectives
Meeting with OHMA Planning Director and Legislative Director (HCC)	May 30, 1974			A. Discussed the relationship of emerging federal legislation and the creation of a state rate-setting agency.
Staff Meeting	June 6 & 7, 1974			A. Task Force reports reviewed and modifications suggested.
HCC Mailing to Advisory Council and Other Interested Groups	June 14, 1974	A. Presentation of policy recommendations and supporting materials.	A. Memorandum of chronology of task force deliberations.	A. Request for feedback regarding the report and recommendations of the task force.
Meeting of Staff and Advisory Council Chairman	June 18, 1974			A. Advisory Council meeting planning session. Discussion of strategies for presentation and discussion of several primary issues.
Advisory Council Meeting	June 27, 1974		A. Forms distributed to Advisory Council members for their indication of interest in serving on two new Advisory Council committees. B. Announcement made that information on responses to questionnaires to be mailed shortly.	A. Health Cost Containment Task Force report received and recommendations modified and accepted. B. Committee appointed to increase consumer participation in Advisory Council proceedings.

WILLIAM G. MILLIKEN
GOVERNOR

STATE OF MICHIGAN
Office of the Governor

Office of Health and Medical Affairs
Lewis Cass Building, Lansing, Michigan 4891
Telephone (517) 373-7662

BRAINSTORMING SESSION

AGENDA

1:30

1. Introduction and Orientation

A. Objective

To generate ideas in the Task Force areas of Cost
Containment, Medicaid, and Maternal and Child
Health regarding:

Problem identification
Priorities of problems
Alternative solutions
Feasibility of solutions
Key groups and individuals relevant
to problems and solutions

B. Procedure

Supplement list of problems previously identified
Individually check priority items from expanded
list
Pool the individual lists
Brainstorm alternatives for high priority problems
Identify key groups and individuals

C. Method

Brainstorm, open-exploration, divergent thinking

1:45

2. Cost Containment

2:45

3. Break

2:55

4. Medicaid

3:35

5. Maternal and Child Health

4:15

6. OHSER Staff Discussion

BRAINSTORMING

The free-wheeling "think panels", first developed by Alex Osborn¹, have become popular for both actual practice and training in the hatching of ideas. The process, when it works, enables individuals and small groups to momentarily abandon their conventional, calculated, logical, sequential, etc., thought processes and free-up or unfreeze in a manner in which new and creative ideas can be brought out into the open for possible future use.

Participants should be in small groups (normally not over 12 to 15 persons in any one group) and seated in a semi-circle around a chalk board, newsprint, etc. A chairman and one or more recorders are selected to facilitate the group's brainstorming session. It is often good practice to use at least two recorders so that all ideas tossed out are captured and kept for future reference.

Oftentimes the success or failure of this process rests upon the person selected to lead the group. Speed and quantity in producing ideas are fostered; the leader endeavors to create an atmosphere of excitement in a game spirit and encourage everyone to come up with bigger and better ideas.

* * * * *

PRINCIPLES FOR "BRAINSTORMING" -- THE PRODUCTION OF ALTERNATIVES

1. You will be more productive of ideas if you refrain from evaluating them or discussing them at the time they are proposed. This is important because education and experience have trained most of us to think judicially rather than creatively. By deferring judgment on our ideas, we can think up far more alternatives from which later to choose.
2. Group production of ideas can be more productive than separate, individual production of ideas. Experiments in group thinking have demonstrated that the average participant in this kind of creative collaboration can think up twice as many possible solutions as when working alone.
3. The more ideas we think up the better. In problem-solving of almost any type, we are far more likely to choose the right path toward solution if we think up 10 ideas by way of possible alternatives instead of only two or three.

¹ Osborn, Alex F., Applied Imagination (New York: Charles Scribner's Sons, Revised Edition, 1957).

PROCEDURES FOR "BRAINSTORMING"

FIRST PHASE: BRAINSTORM the problem according to the following rules:

- A. All critical judgment is ruled out; no evaluation of ideas is allowed. The group is seeking ideas -- any kind of ideas -- solid, off-beat, even impractical; all are encouraged.

Ignore critical comments unless they persist -- then remind the violator(s) of this rule.

- B. Wild ideas are expected in the spontaneity which comes when we suspend judgment. Practical considerations are not of importance at this point; oftentimes a crazy, wild, impractical idea becomes the stimulus or frame upon which a good, usable, practical idea is developed.
- C. Quantity of ideas counts here, not quality.
- D. Build on the ideas of other brainstormers whenever possible; "hitch-hiking" or piggy-backing" on others' ideas is encouraged.

SECOND PHASE: Now CRITICAL JUDGMENT is applied:

- A. Members should review the ideas by applying their best judgment.
- B. Members should be urged to seek for clues to something sound in the wildest idea.
- C. Priorities should be selected for reporting to the decision-making person or group.

COST CONTAINMENT TASK FORCE
FOLLOW-UP QUESTIONNAIRE

The following list contains nineteen statements which appear to represent the total response to Question 2 of the Cost Containment Task Force questionnaire (above). Please select the ten statements that you feel are the most important for this Task Force to focus on now and place a check mark in the space next to the selected statements. The returns will be tabulated in terms of statements selected by percentage of Task Force members.

You may return the completed questionnaire using the enclosed envelope, or bring it with you to the October 24 meeting.

- ☐ 1. Lack of incentives for providers and consumers to contain health care costs.
- ☐ 2. Lack of effective utilization review programs or patient management system.
- ☐ 3. Unreasonable levels of expectations and demands by consumers with stable supply of doctors.
- ☐ 4. Lack of vigorous competition in the structure of the health care delivery system.
- ☐ 5. Lack of a viable system for the prevention of illness.
- ☐ 6. Unreasonable malpractice judgments prompting skyrocketing premiums.
- ☐ 7. Rising salaries for health care employees.
- ☐ 8. Growing consensus that the availability of health care should be guaranteed to all citizens.
- ☐ 9. Lack of alternative systems of providing health services.
- ☐ 10. Inflation in general.
- ☐ 11. High priorities for research, technology and equipment.
- ☐ 12. Lack of effective planning and economic practices.
- ☐ 13. Costs of medical education.
- ☐ 14. Rigidity in categories of health care personnel roles and functions.
- ☐ 15. Overbuilding.

- _____ 16. Duplication of services.
- _____ 17. The separation of authority and accountability for economic decisions.
- _____ 18. Difficulty in measuring the quality and cost of care which prohibits comparative data.
- _____ 19. Cost - plus reimbursement principles.
- _____ 20. Other factors related to cost containment.

MEDICAID TASK FORCE SUPPLEMENTARY LIST

Statistics

- 500,000 persons ages 0-20 years are eligible under the new Early Periodic Screening, Diagnosis and Treatment program which has a \$30 million allotment.
- \$35/month is the average spent per recipient.
- 35% of all state Medicaid monies are spent on nursing home care for the elderly while 5-10% is spent for care of the under 21 years population.
- care in a nursing home costs approximately \$8,000/year per person.

Problems

- over-utilization of hospitalization
- use of out-patient facilities rather than physicians' offices
- need to fill gap between elderly living alone and living in nursing homes

Dr. Feingold then spoke to the problems he felt needed the attention of the Task Force:

- no overall plan for social needs in the State.
- Medicaid is largely a program for persons under 21 years and over 65 years of age.
- no decisions are made on expenditures in order to create a balance between services.
- no tie to state health care plan.

The Task Force members continued a very general discussion of the problems of Medicaid and the problem with accomplishing the objectives within the given time constraints.

The group agreed that it needs more information before deciding priorities. Mrs. Grove read the draft of a letter to go from the Task Force to provider and consumer groups. She also recommended that responses be requested by October 15 to be reviewed by Dr. Feingold before the next Task Force meeting.

The next meeting was set for October 22, 1973.

The meeting was adjourned at 11 a.m.

PROBLEMS - MATERNAL AND CHILD HEALTH

1. Abortion services are not available throughout the state, and there doesn't seem to be a method to assure the quality of care when services are available.
2. Genetic counseling services are not available throughout the state.
3. In some areas of the state, especially the northern lower peninsula, large numbers of women are delivering with no prenatal care.
4. A large number of the births in the state occur in small community hospitals. The size of the hospital (# of deliveries) appears to be a factor related to pregnancy outcome.
5. Large numbers of children, especially in metropolitan areas, have not received immunizations.
6. Although public family planning services are available to persons in all 83 counties, these services are fragmented and often isolated from other health services.
7. Fragmentation of all child health clinics i.e. EPSDT, child health clinics, pediatric care, school health services.
8. Over-emphasis in allocation of resources to late treatment or rehabilitative services rather than on preventive, detection, and early treatment services.
9. Method of financing care for the children of the working poor.
10. Families need more in the way of health education in order to facilitate efforts to prevent and detect child health problems.

October 3, 1973

Governor Milliken has charged the State Health Planning Advisory Council with the responsibility of examining the State's Medicaid Program and making recommendations concerning its future development. He specifically requested the Council to solicit the views and opinions of consumer and provider groups regarding problems that may be encountered in the Medicaid Program and their possible solution. The Advisory Council has created a Task Force to carry out this activity.

The Task Force has identified several areas that might be examined for possible revision. These areas include:

1. The amount paid to physicians by Medicaid is established by the prevailing fee charged by physicians in the area for the same services. Has this reimbursement method produced any side effects?
2. Do Medicaid eligibles know and understand the procedures and benefits of the Medicaid program?
3. What are the effects of the Medicaid eligibility determination system?
4. Are Medicaid billings and reimbursements efficiently handled?
5. How does Medicaid affect the availability of facilities and physicians?
6. How complete are the Medicaid covered services?
7. Generally, Medicaid is available to persons eligible for Old Age Assistance, Aid to the Blind, Aid to the Permanent and Totally Disabled and Aid to Families with Dependent Children. Is this coverage sufficient to meet the needs of the population?
8. How do enrollment fees and deductibles affect utilization by the medically needy?

In order to carry out its charge the Task Force would like your organization to comment upon the above areas, whether in your experience you have encountered problems and whether you have any recommendations for improvement. You should feel free to comment upon additional areas that you think this Task Force should consider. So that all responses can be considered by the Task Force we would like to receive your comments by October 15.

Sincerely,

Barbara J. Grove, Chairperson
Medicaid Task Force

Medicaid Letters of 10/4/73 Asking for General Concerns -
80 letters (probably more) 55 responses

- *Southwest Crisis Center
- *Directors of the 10 "b" agencies - 1 response
- *Senior Citizens Fund - Benson Hitchcock, Executive Director
Michigan Pharmaceutical Association
- *United Migrants for Opportunity
Citizens Congress, Inc.
- *Citizens for Better Care, Inc. - Charles Chomet, Executive Director
- *33 Legal Aid Society Offices - 5 responses
- *West Side Mothers - Selma Goode
Michigan Welfare Reform Coalition
Community United for Action, Inc. - Georgia Brown, Executive Director
New Detroit Corp.
Medical Committee for Human Rights
- *Model Neighborhood Agency - 8 - 1 response
Southwest Community Alliance
- *All County Medical Society Presidents - 23 responses
- *CAP Agencies - 29 - 12 responses
- *Mayor's Committee for Human Resources Development - Detroit
- *Michigan Ass'n. of Osteopathic Physicians & Surgeons - George Abdilla
Michigan Hospital Association
- *Michigan Nurses Association - Joan Guy
- *Lansing VNA - Helen Goodwin
Detroit VNA - Sylvia Peabody
- *Michigan Dental Association - 2 responses
Michigan Nursing Home Association - Charles Harmon, Executive Director
Michigan Welfare Rights Organizations - 19
Southwest Community Alliance
Michigan League for Human Services
- *Cristo Rey Community Center
- *Blue Cross of Michigan - V.P. for Gov't Affairs Gerald P. Kearney, Jr.
- *Metropolitan Hospital and Health Centers

* Responses Received

STATE HEALTH PLANNING ADVISORY COUNCIL
TASK FORCE ON COST CONTAINMENT

It was decided at the August 15, 1973 meeting of the Task Force to ask each member to respond to the following two questions (please limit response to one paragraph):

1. What do you think this Task Force should ultimately accomplish by way of affecting health care cost containment in Michigan?

COST CONTAINMENT TASK FORCE
FOLLOW-UP QUESTIONNAIRE

The following list contains nineteen statements which appear to represent the total response to Question 2 of the Cost Containment Task Force questionnaire (above). Please select the ten statements that you feel are the most important for this Task Force to focus on now and place a check mark in the space next to the selected statements. The returns will be tabulated in terms of statements selected by percentage of Task Force members.

You may return the completed questionnaire using the enclosed envelope, or bring it with you to the October 24 meeting.

- ☐ 1. Lack of incentives for providers and consumers to contain health care costs.
- ☐ 2. Lack of effective utilization review programs or patient management system.
- ☐ 3. Unreasonable levels of expectations and demands by consumers with stable supply of doctors.
- ☐ 4. Lack of vigorous competition in the structure of the health care delivery system.
- ☐ 5. Lack of a viable system for the prevention of illness.
- ☐ 6. Unreasonable malpractice judgments prompting skyrocketing premiums.
- ☐ 7. Rising salaries for health care employees.
- ☐ 8. Growing consensus that the availability of health care should be guaranteed to all citizens.
- ☐ 9. Lack of alternative systems of providing health services.
- ☐ 10. Inflation in general.
- ☐ 11. High priorities for research, technology and equipment.
- ☐ 12. Lack of effective planning and economic practices.
- ☐ 13. Costs of medical education.
- ☐ 14. Rigidity in categories of health care personnel roles and functions.
- ☐ 15. Overbuilding.

- _____ 16. Duplication of services.
 - _____ 17. The separation of authority and accountability for economic decisions.
 - _____ 18. Difficulty in measuring the quality and cost of care which prohibits comparative data.
 - _____ 19. Cost - plus reimbursement principles.
 - _____ 20. Other factors related to cost containment.
-
-

MEMORANDUM

State of Michigan
EXECUTIVE OFFICE
Lansing

To: Members of the State Health Planning
Advisory Council
From: Donald C. Smith, M.D., Principal Advisor
on Health and Medical Affairs
Subject: Development of a State Health Plan - Definition of Responsibilities

Date: January 4, 1974

The following statement has been prepared by Mr. Endsley and members of our planning staff. Its purposes are (a) to provide further detail on the 17 elements listed in the State Health Planning Agency Performance Standards, which you received in December, and (b) to suggest respective areas of responsibility for the Advisory Council and the Office in development of the State Health Plan for Michigan.

This statement will, I believe, be useful to our continuing discussions concerning formulation of the Plan. Your comments and suggestions would be appreciated. I would ask that you send these directly to Mr. Endsley before the January 24 meeting of the Advisory Council. This will enable us to prepare for a discussion on the statement at that time. Mr. Endsley's title and address are: Jay G. Endsley, Assistant Director for Comprehensive Health Planning, Office of Health and Medical Affairs, 1st floor, Lewis Cass Building, Lansing, Michigan, 48913.

For purposes of clarification, the 17 elements contained in the Agency Standards are listed below.

Elements

1. The Agency Should Establish A Planning Framework.
2. A Process And Timetable For Health Plan Development Should Be Determined.
3. Responsibilities Of Staff, Advisory Council, And Others Should Be Assigned.
4. Area Health Needs Should Be Identified.
5. Future Health Needs Should Be Projected.
6. Area Health Resources Should Be Inventoried.
7. Health Resources Should Be Analyzed.
8. Broad Health Goals Should Be Established Based On State Health Needs And Resources.
9. Priorities Should Be Determined.
10. Objectives Should Be Developed Based On State Goals And Needs.
11. Alternative Means To Accomplish Objectives Should Be Analyzed.
12. The Preferred Alternatives Should Be Selected And Recommendations Developed.
13. An Implementation Strategy And Schedule Should Be Developed.
14. The Plan Should Provide A Base For Facilities And Services Review.
15. The Plan Should Be Published.

16. Plan Recommendations Should Be Disseminated.
17. Plan Evaluation and Revision Should Occur Periodically.

Introduction

The development of a State Health Plan for Michigan is an ongoing process rather than a one-time event. While we will periodically produce editions of the plan, its component parts and the entire plan will be subject at any time to additions, updating and other changes.

It is expected that a State Health Planning Agency will have completed the first draft of a State Plan within two years after its formation. For this purpose, we will begin the two-year period in May of 1973 when the new State Health Advisory Council held its first meeting. It is anticipated that Elements 1, 2 and 3 will constitute a plan for the plan and will be complete by June of 1974.

- Element 1. The Agency Should Establish A Planning Framework.
- Element 2. A Process And Timetable For Health Plan Development Should Be Determined.
- Element 3. Responsibilities Of Staff, Advisory Council, And Others Should Be Assigned.

The responsibility for these three elements is shared by the Advisory Council and the Office of Health and Medical Affairs. This paper constitutes a first step in Element 3. Other preparatory work by the Office of Health and Medical Affairs and discussions and action by the Advisory Council in the coming months will determine the framework, process and timetable. A paper on a possible format for organizing the State Health Plan is being prepared by the Office of Health and Medical Affairs for presentation to the Advisory Council at the February meeting.

- Element 4. Area Health Needs Should Be Identified.

The delineation of State Health needs should be a joint responsibility of the Advisory Council and the Office of Health and Medical Affairs. There is a wide variety of methods available to identify such needs. It seems reasonably clear that all statistical information leading to the identification of health needs should be developed or obtained from other sources and then summarized and analyzed by the staff of the Office of Health and Medical Affairs. In addition to the appropriate statistical information we will need to develop a methodology for soliciting citizen perceptions of health needs throughout the State. Several of the more experienced areawide and state health planning agencies have developed methodology for determining citizen perceptions of health needs and other methods appropriate for determining areas of deficiency in the health system. Obtaining and analyzing these methodologies and making recommendations as to their applicability at the state level seems to be a function of the Office of Health and Medical Affairs. Upon completion, this material will be forwarded to the State Health Planning Advisory Council for discussion and decision.

Element 5. Future Health Needs Should Be Projected.

The projection of health needs in most instances can be best accomplished through the utilization of statistical analysis. The Office of Health and Medical Affairs is appropriately staffed and has access to pertinent data to make such projections. The task of defining desired conditions or outcomes for future events is a joint responsibility of the Advisory Council and the Office of Health and Medical Affairs using the appropriate statistical material.

Element 6. Area Health Resources Should Be Inventoried.

An inventory of existing and planned health services for the state is currently being prepared by the Office of Health and Medical Affairs and should be available for review by the Advisory Council in the summer of 1974. The Office of Health and Medical Affairs is using a wide variety of techniques to develop this inventory.

Element 7. Health Resources Should Be Analyzed.

This element obviously follows the inventory developed under Element 6. For example, the Office of Health and Medical Affairs is beginning work in the field of visual care as a first step toward the delineation of manpower needs in Michigan for the 14 licensed professions. It is anticipated that this methodology will be applicable for the analyses of other health manpower resources in the state.

There are a number of steps in the analysis of a health services inventory which will benefit from review by members of the Advisory Council. This is particularly true of such issues as the acceptability of services and the identification of overlaps and gaps in service. Since most of the inventory work will be taken from the output of the provider agencies, the review and comment by consumer members of the Advisory Council will be extremely beneficial in preventing the inventory from becoming a provider based product and therefore subject to criticism as the "professional" view.

Element 8. Broad Health Goals Should Be Established Based On State Health Needs And Resources.

Element 9. Priorities Should Be Determined.

Element 10. Objectives Should Be Developed Based On State Goals And Needs.

The establishment of goals, priorities and objectives are clearly the responsibility of the State Health Planning Advisory Council. The method used in development of goals, priorities, and objectives should also be developed by the Advisory Council. To assist the Council in this activity the Office of Health and Medical Affairs is developing a list of alternative processes which could be used by the Council in the determination of goals, priorities, and objectives. Again, a note of caution neither this list nor the paper on a possible framework will constitute a final position in the area that it addresses. Rather, they are both designed to be the basis for further discussions and decision by the Advisory Council. Both papers will be presented to the Advisory Council at the February meeting.

Element 11. Alternative Means To Accomplish Objectives Should Be Analyzed.

Element 12. The Preferred Alternatives Should Be Selected And Recommendations Developed.

As mentioned in the Agency Performance Standards there may be alternative courses of action which will lead to the accomplishment of stated objectives. The Office of Health and Medical Affairs, based on financial, technical and political feasibility and with review and comments by the Council will select which alternative actions are most likely to accomplish the stated objective.

Element 13. An Implementation Strategy And Schedule Should Be Developed.

The development of an implementation strategy and schedule should be handled in two ways. The first method is for the Advisory Council and the Office of Health and Medical Affairs to jointly determine which agencies and/or people are most likely to be affected by the plan itself and then develop a suitable strategy and time schedule for implementation. The second method is to build into each component of the plan a time schedule and strategy for implementation. At a minimum each component should provide that the comprehensive health planning agency maintains overall responsibility for policy development and continuing review of the performance of the agencies affected by the component.

Element 14. The Plan Should Provide A Base For Facilities And Services Review.

The Executive Committee of the Advisory Council is considering how the review and comment responsibilities of the Advisory Council and the Office of Health and Medical Affairs can best be developed.

Element 15. The Plan Should Be Published.

Element 16. Plan Recommendations Should Be Disseminated.

Both of these elements are clearly responsibilities of the Office of Health and Medical Affairs. In essence they consist of the editorial work necessary prior to publication and mechanical process of having the material published. The actual distribution of the plan is also the responsibility of the Office of Health and Medical Affairs. The Advisory Council's input would be extremely helpful in determining the size of the distribution and the types of agencies and/or people who should receive copies of the plan and other Advisory Council output.

Element 17. Plan Evaluation and Revision Should Occur Periodically.

This element is a joint responsibility of the Office of Health and Medical Affairs and the Advisory Council. The timing of the evaluation and the type of evaluation and the types of revision necessary will be discussed in depth with the Council as the development of the plan proceeds. In addition each component of the plan should have its own internal evaluation and revision structure. This is necessary since implementation of the plan is clearly not the responsibility of either the Office of Health and Medical Affairs or the Council, but rather that of a wide variety of operating agencies, both public and private.

JGE:jn

MEMORANDUM

State of Michigan
EXECUTIVE OFFICE

Office of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-7688
8155

To: State Health Planning Advisory Council Members

Date: February 8, 1974

From: Donald C. Smith, M.D.

Subject: Draft Format For The State Health Plan

As you will recall from the discussions at the January Advisory Council meeting, the staff of the Office of Health and Medical Affairs was asked to:

1. develop a working paper on the format, or organizational outline, of the state health plan, and
2. prepare a working paper on the process, or alternative processes, which could be utilized by the Council and our staff in the development of the state plan.

It is intended that these two working papers, together with the memo on the definition of responsibilities, which you have already received, comprise the basis for ongoing discussions at Council meetings between now and June. It is anticipated that at our June meeting the Council and our staff will have jointly agreed upon "a plan for a plan." Using this timetable, our staff could devote much of the summer to the preliminary staff work necessary to begin the development of the state health plan starting in September of 1974. Again, it should be remembered that these papers serve as points of departure and the basis for further discussions. They are in no way intended to be final positions with regard to the issues they discuss.

For background purposes, the following excerpts from the Executive Order 1972-12 which creates the Office of Health and Medical Affairs and the State Health Planning Advisory Council are included:

- "1. To develop and periodically revise a state health plan encompassing both publicly and privately supported health services, facilities, and manpower to meet the physical, mental, and environmental health needs of the people of Michigan.

It is the intent of this Order that the state health plan be developed in stages, subsequently combined to render the plan "comprehensive". In addition to statistical and professional descriptions of health status and health care needs, the plan shall contain policy recommendations for approval by the Governor. Upon approval, the plan shall serve as the principal guide to all agencies in the Executive Branch in developing health program policy and programs.

2. To review and make recommendations to the Governor and the Director, Bureau of Programs and Budget, for action on all state plans for developing or funding health services, facilities or manpower

under federal or state programs to assure their being in accordance with the state health plan. Program planning and implementation shall continue to be the responsibility of the various state departments.

3. To ensure cooperative planning among governmental and non-governmental agencies concerned with health services, facilities or manpower and between health agencies and agencies concerned with education, welfare, rehabilitation and the environment.

In performing the above duties, the Office shall:

- a. establish, in conjunction with the heads of major health-related departments, a system for state health planning comprised of the following functional components: (1) research, (2) policy development, (3) program development, and (4) evaluation.

It is the intent of this Order that the Office utilize existing resources within and without state government in organizing each of the functional components. Public and private organizations, including areawide health planning agencies, who function primarily in the areas of statistics; basic and applied research; policy analysis; program planning, development and operation; and policy and program evaluation should be considered for incorporation in the system.

- b. establish an on-going process for state health planning, involving the following steps: (1) establishing goals, (2) documenting needs and identifying problems, (3) recommending priorities, (4) developing alternative solutions, and (5) assessing impact of policy and programs."

In order to fulfill the intent of the Executive Order as well as to make full use of the work activities in which the Council is currently involved, i.e., Medicaid, cost containment and maternal and child health, etc., the following format or organizational outline for the plan is offered:

The plan would be organized in four basic sections. The first section would include a broad statement of health goals for the state. In addition to these goals, health priorities for the state would be identified by the Council and our staff. Because of the constraints on the resources of our staff and the Council, it is obviously not possible to address all priority items simultaneously. Therefore, a mechanism would be developed and applied in this section to rank the identified priorities and to determine objectives.

The remainder of the plan would be grouped in three categories.

Category 1: Functional issues or general issues. These are broad issues which cut across traditional programmatic or agency priorities. Examples are cost containment, regionalization, health research, manpower, health education, etc.

Category 2: Categorical programs. These are traditional, specialized programatic issues. Examples include emergency medical services, maternal and child health, Medicaid, communicable diseases, etc.

Category 3: Special issues. This section provides a way to deal with issues that do not fit neatly into either of the other two categories and yet are significant for consideration by the Council and our staff. Examples are such issues as health services for migrants and Indians, alternative systems for the delivery of health care, services for the rural poor, etc.

This format is based on three major considerations. The first is that we should be able to capitalize on past and current activities of the Council and our staff and to utilize this work in the final development of the state plan. A second benefit of this structure is that it would allow the Council and our staff to determine which activities they will address and at what time, depending upon both staff and fiscal resources of our staff and the Council. A third advantage of this format is that it would provide flexibility, allowing the Council and our staff to address issues that arise during the planning process from the Governor's Office, the Legislature, or other sources.

MEMORANDUM

State of Michigan
EXECUTIVE OFFICE
Lansing

To: Governor Milliken

Date: February 7, 1974

From: Donald C. Smith

Subject: Progress report - Policy Statements on Maternal and Child Health, the Medicaid program and Health Cost Containment.

This will bring you up-to-date on action taken on your request to the State Health Planning Advisory Council (see attached letter, dated April 19, 1973) that it give major attention to these three substantive areas in the coming year. Task Forces were formed for each area, substantial work has been done to explore existing problems and each Task Force has determined priorities for their remaining work. Resources of both public and private agencies and organizations throughout the state are being utilized and, in addition to my staff, each Task Force has the expert assistance of consultants from appropriate State university departments.

Recommendations to you from the Advisory Council can be expected no later than June 1974 concerning the following issues:

Maternal and Child Health In addition to the policy statement on perinatal intensive care which you endorsed in October, this Task Force will formulate recommendations designed to create a framework integrating current maternal and child health and children and youth programs into a single system to assure more continuous and comprehensive care. Recommendations concerning quality standards for family planning and abortion services and the more effective use of school health programs may also be expected.

Medicaid Alternatives to long term care, such as that provided in nursing homes, was chosen by this Task Force as an area in need of immediate improvement in the Medicaid program, from among the many related to the delivery of adequate, quality health services to the poor and near poor of Michigan. A primary consideration in this choice was the fact that long term care consumes the lion's share of the Medicaid budget (38% in FY 1972), while providing this service to only 4.7% of Medicaid recipients. Recommendations on Medicaid support for such alternatives, including home health care, can be expected.

Health Cost Containment Over twenty major causative factors of spiraling health care costs have been identified and analyzed. Among these, this Task Force decided that recommendations concerning the lack of incentive reimbursement offer maximum potential for effective action. It is hypothesized that the use of criteria other than cost could provide institutions with incentives for cost control that could impact on 80 to 85% of hospital revenue currently obtained through reimbursement of costs and that the scope of such change could materially affect most other problem areas analyzed by the Task Force. Federal encouragement of incentive reimbursement mechanisms, experience of other states, and active experimentation by provider groups in the State are additional factors which make it seem politically, economically and technically feasible to develop recommendations in this area.

Governor Milliken
Page 2
February 7, 1974

It is important to note that the process being used by the Task Forces and the Advisory Council in developing recommendations provides for the drafting of preliminary recommendations. These are then modified after consultation with appropriate governmental and non-governmental groups and individuals, both those who will be affected by recommendations and those who will have to take action as a result of such recommendations. In this way, it is expected that critical features of the final recommendations will have had discussion and preliminary acceptance by a wide audience before submission to you.

MEMORANDUM

State of Michigan
EXECUTIVE OFFICE

Office of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-7688

To: Presidents of Areawide Comprehensive Health Planning Agency Boards
Areawide Comprehensive Health Planning Agency Directors
Date: February 8, 1974

From: Robert J. Yellan, Staff Planner
Maternal and Child Health Task Force *RY*

Subject: Maternal and Child Health Task Force of the State Health Planning
Advisory Council

As you probably know, the State Health Planning Advisory Council, with the assistance of the Office of Health and Medical Affairs, is currently involved in the development of state policy on maternal and child health. Many of you have seen the policy statement on perinatal intensive care, which was prepared by this Task Force last fall. The Task Force is now concentrating on broader areas of concern in maternal and child health.

Primary emphasis is currently being placed on reducing the fragmentation of primary health care services for mothers and children in Michigan. Screening programs, family planning services, well-child services, immunization clinics, etc., each in isolation limits the comprehensiveness of health care for Michigan families. Furthermore, fragmentation hinders the appropriate utilization of available health services. The Task Force hopes to make recommendations which will lead to action which would minimize these statewide problems.

The Task Force also anticipates making recommendations aimed at assuring that care received in abortion and family planning services is of the quality required to protect the people of Michigan. This area was identified by Governor Milliken as a priority area in maternal and child health in his special message on human services.

A third area of Task Force consideration, if time allows, will be the area of school health services. Nearly one-third of the state's population attends school regularly. The potential of providing health services in the school setting has long been recognized, but the commitment to school health services varies greatly throughout the state.

I have already spoken to some of you about specific problems in data collections, special geographic concerns, and other areas, and hope to continue to do so as Task Force deliberations proceed.

When the Task Force has reached the point of drafting preliminary recommendations, it would be most helpful if we could have any comments you might have regarding the recommendations. It is anticipated that these preliminary recommendations will be prepared by the middle of March.

Because of the nature of our federal grant funding, the turnaround time on our need for comments and suggested modifications of the recommendations will be extremely short. However, any assistance in this area you may lend to us would be greatly appreciated.

RY:nh

"b" Agency Directors

Date: January 18, 1974

From: Carol Hesselbacher
Staff to Medicaid Task Force

Subject: Medicaid Task Force work

The Medicaid Task Force of the State Health Planning Advisory Council at its January meeting decided to study the problem of nursing home care and the lack of alternatives to institutionalization with the intent to make recommendations for changes in the Medicaid program. In FY 1971, 4.7% of the Medicaid recipients were in nursing homes, yet payment for nursing home care consumed 38% of total program expenditures - the largest single benefit expenditure under the Michigan Medical Assistance Program.

Alternatives to institutionalization, such as Medicaid-covered home health care, would be preferable to many nursing home patients who, if they had a few maintenance services available to them, could remain in their homes in a normal societal setting.

The Task Force would like to learn about regional differences in treatment of the chronically ill and any suggestions you may have to deal with some of the current problems in nursing home care. If you know of other groups or individuals in your area with special knowledge on this subject, please let me know. Also, if you have data available on nursing homes and both public and private home health services in your region, I would appreciate receiving copies of it. A list of specific data needs is attached.

Due to the tight time schedule for the Task Force's work, it would be most helpful if you could send us whatever information you have by February 15. After that date we could continue to communicate on additional information gathered.

If you have any questions about the work of the Task Force, please call me at (517) 373-8155.

CH/dp

Enclosure

While I have listed all of the data we would ideally like to have, I realize that it may not be readily available. Any portion of the information requested would be appreciated.

Number of long term care beds

- skilled
- basic
- homes for the aged

Number of public home health agencies

- services offered
- number of personnel offering various services
- estimated capacity service population
- population served by age, reimbursement mechanism and type of care required

Number of private home health agencies

- services offered
- number of personnel offering various services
- estimated capacity service population
- population served by age, reimbursement mechanism and type of care required.

Can you get any information on the types of Medicaid recipients in nursing homes?

MEMORANDUM

State of Michigan
EXECUTIVE OFFICE

Office of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-7688

To: Areawide Comprehensive Health Planning
Agency Directors

Date: February 8, 1974

From: Carol Hesselbacher, Staff Planner
Medicaid Task Force

CHH

Subject: Review and Comment Procedure for Home Health Agencies

I would like to thank those of you who have sent the data which I requested on nursing homes and home health agencies in your area.

I also would like to solicit your agency's opinions on a topic which is likely to arise in the Medicaid Task Force's deliberations. Attached is a copy of a letter which I have sent to the presidents of your agency's board. I am hoping to receive input from both the agency and the board on this matter.

Thank you for your time and consideration.

CH:nh

enclosure

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MEMORANDUM

State of Michigan
EXECUTIVE OFFICE

Office of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-~~XXXX~~
8155

To: Presidents of Areawide Comprehensive Health Planning
Agency Boards

Date: February 8, 1974

From: Carol Hesselbacher, Staff Planner
Medicaid Task Force

CHH

Subject: Review and comment procedure for home health agencies

As you may know, the State Health Planning Advisory Council has formed a Medicaid Task Force at the request of Governor Milliken to explore the problems of the Medical Assistance program (Medicaid) in Michigan. The Task Force has been looking into a number of problems and has decided to concentrate its efforts on the problems of alternatives to long term institutional care. Nursing home care accounts for over 40% of the entire state Medicaid budget while serving only about 5% of the Medicaid recipients.

One possible solution to the problem of inappropriate institutionalization is extension of home health benefits. On this subject, I would like to solicit your Board's opinions on a topic which is likely to arise in the Task Force's deliberations. Under Section 1122 of the Social Security Act, states are empowered to require that home health agencies undergo the same review and comment procedure currently used by the Areawide Comprehensive Health Planning Agencies with regard to hospitals.

At present, proprietary homemaker organizations are not permitted to deliver home health services under Medicare or Medicaid in Michigan. Questions to be asked in deciding whether to certify proprietary agencies and whether to require review and comment on all home health agencies are:

- would competition among public and private agencies improve service or would it create confusion for persons needing service?
- does your agency have the capacity to provide review and comment on home health agencies?
- do you think review and comment on home health agencies would be useful? why?

Due to the tight time schedule under which the Task Force is working, your input on this matter would be of the greatest help if we could receive your reply by early to mid March.

Thank you for your time and consideration.

CH:nh

cc: Directors, Areawide Comprehensive Health Planning Agencies

MEMORANDUM

State of Michigan
EXECUTIVE OFFICEOffice of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-7688
8155

To: Presidents of Areawide Comprehensive Health Planning Date: February 8, 1974
Agency Boards
Areawide Comprehensive Health Planning Agency Directors

From: James R. Bernthal, Staff Planner *JB*
Health Cost Containment Task Force

Subject: The Health Cost Containment Task Force of the State Health Planning
Advisory Council

The purpose of this memo is to provide you with a thumb-nail sketch of the work of the Health Cost Containment Task Force, and to invite you to contribute to the process of developing meaningful recommendations in the area being studied by the Task Force.

In April, 1973, Governor Milliken directed the State Health Planning Advisory Council to develop measures aimed at containing the rising costs of health care. Nineteen members of the Advisory Council formed a Task Force to respond to this mission.

The Health Cost Containment Task Force, under the leadership of Mr. Peter Wege, began meeting in July, 1973. They defined cost containment as decreasing the rate of inflation of health care costs and they decided to develop policies which, through legislation or regulation, would form the basis of a cost containment strategy.

Since that time the Task Force has identified and analyzed over twenty major causative factors of spiraling health care costs. In their effort to zero in on the problem, it was decided that the concept of incentive reimbursement offered maximum potential for effective action. Incentive reimbursement was broadly defined by Dr. Paul Ginsburg, primary consultant to the Task Force, as any system where third party payors use factors other than cost in determining payments to hospitals and nursing homes. It was hypothesized that the use of reimbursement mechanisms, other than cost reimbursement, would provide institutions with incentives for producing cost-reducing changes in their behavior, which would affect 80-85% of hospital revenue currently obtained through reimbursement of costs; and that the scope of such changes would materially affect most of the problem areas analyzed by the Task Force. It was further thought that the evidence of federal encouragement of incentive reimbursement mechanisms, the experience of other states, and the active exploration and experimentation by provider groups of the State of Michigan made it politically, economically and technically feasible to develop recommendations in this area. The staff of the Task Force is presently working on the following tasks as groundwork for the development of policy recommendations:

1. Defining and categorizing basic elements and characteristics of incentive reimbursement. This includes discussion of such issues as the degree of control by the third party payor; whether the program is voluntary or mandatory; what are the methods of rate determination; and so forth.
2. Developing criteria for evaluating existing programs and experiments and for designing the assessment of recommendations coming out of the present Task Force.

3. Describing existing plans, programs and experimentation with incentive reimbursement.
4. Analyzing research findings regarding various incentive reimbursement mechanisms.
5. Projecting the potential benefit of recommendations and assessing the viability and feasibility of such recommendations.

The Task Force would welcome communicating with you and receiving your input into the analysis and the development of policy recommendations. We would also appreciate your help in identifying resources and your participation at proposed solution exploration seminars. The Task Force will be happy to provide you with information regarding our work and will also provide you with our preliminary recommendations. Should you, a member of your staff, or a member of your board wish to attend a Health Cost Containment Task Force meeting, please notify me and I will provide you with a schedule of the meetings.

JRB:nh

STATE HEALTH PLANNING ADVISORY COUNCIL

Glossary of Terms

Office of Health and Medical Affairs
March 1974

Federal Agencies and Programs

HEW - (Department of Health Education and Welfare) is a Cabinet-level department of the Federal executive branch created in April, 1953. The various offices and their responsibilities can be seen on the attached organizational chart and in the descriptions below.

PHS - (Public Health Service) has as its original function the authorizing of marine hospitals for the care of American merchant seamen. Subsequent legislation has vastly broadened the scope of its activities. Within its five operating agencies, PHS oversees the comprehensive health planning program (under which the Office of Health and Medical Affairs and the Advisory Council are funded), regional medical program authorizations, and other programs for improving delivery of health care. The five operating agencies are:

- 1) FDA - (Food and Drug Administration) acts to protect the health of population against impure and unsafe foods, drugs, cosmetics, hazardous radiation exposure, and other potential hazards.
- 2) NIH - (National Institutes of Health) conducts and supports biomedical research into the causes, prevention and cure of diseases and disseminates biomedical information. Among the institutes are the National Cancer Institute, National Heart and Lung Institute, the National Institute of Child Health and Human Development.
- 3) HRA - (Health Resources Administration) provides national leadership related to the requirements for, and distribution of health resources. Comprehensive health planning services are located in HRA, as are the Bureau of Health Manpower Education, Health Care Facilities Service (which administers Hill-Burton capital expenditure funds), Health Maintenance Organization Service, National Center for Health Services Research and Development, National Center for Health Statistics, National Health Services Corps and Regional Medical Program Service.
- 4) HSA - (Health Services Administration) provides professional leadership in the delivery of health services to special population groups. Included in HSA are the Community Health Service, Federal Health Programs Services (involves only health care for designated federal employees and their dependents), Indian Health Service and the Maternal and Child Health Service and the National Center for Family Planning Services.
- 5) CDC - (Center for Disease Control) administers national programs for the prevention and control of vector-borne diseases and other preventable conditions, including the control of childhood lead-based paint poisoning, urban rat control, venereal disease, tuberculosis and immunization programs.

- SRS - (Social and Rehabilitation Service)- administers the federal programs providing technical, consultative and financial support to states, local communities and other organizations in the provision of social, rehabilitation, income maintenance, medical and other necessary services provided to the aged, disabled, children and families in need. Included under SRS is the Medical Services Administration, which administers programs that provide medical services to the needy and the medically needy through grants to the states (Medicaid).
- SSA - (Social Security Administration)- administers a national program of social insurance in which employees, employers and the self-employed pay contributions which are pooled in special trust funds. When earnings stop or are reduced because the worker retires, dies or becomes disabled, monthly cash benefits are paid to replace part of the earnings that the family has lost. Another portion of the money goes into a separate hospital insurance trust fund, so that when workers and their dependents become 65 years old they will have help with their hospital bills (Medicare). In addition, the SSA administers the new SSI (Supplemental Security Income) program under which the federal government took over payment of public assistance grants to persons who qualify for Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to Disabled (AD), though not to persons receiving public assistance under Aid to Families with Dependent Children (AFDC or ADC). In Michigan, the state supplements the federal payment.
- Hill Burton funds - federal funds provided to health care facilities for construction or renovation of additional beds. The program has served as a source of federal control in the hospital industry in particular.
- RMP - (Regional Medical Programs) - originally established under federal law with total federal funding to disseminate information to the medical professions about changes in treatment of heart, stroke and cancer, RMP's have significantly broadened the scope of their interest and activities to include almost any field of medical science and delivery of care. In Michigan, the two RMP organizations joined to become the Michigan Association for Regional Medical Programs (MARMP) whose advisory council is called the Regional Advisory Group (RAG).
- SAB - (State Advisory Boards) - are designated by the governors of each state for the purpose of considering health services aspects of the federal Economic Stabilization Program (ESP) as outlined by the Cost of Living Council (COLC or CLC). In Michigan the SAB is organized through the Office of Health and Medical Affairs with an outside membership of consumers and providers. The SAB rules on requests from institutional providers to increase revenues above the federally-established maximum.
- Medicare - hospital and medical insurance paid for primarily from Social Security revenues. All U.S. residents 65 years and older, as well as certain categories of disabled persons, who have paid into the Social Security fund qualify to receive benefits.

Medicare - hospital and medical insurance paid for primarily from Social Security revenues. All U.S. residents 65 years and older, as well as certain categories of disabled persons, who have paid into the Social Security fund qualify to receive benefits.

Medicaid - a federal/state program under which the federal government has attempted to provide payment for the health needs of the poor. Persons qualifying for public assistance in a state also qualify for Medicaid benefits which are paid for from state and federal revenues. Unlike Medicare, which has a standard benefit package, Medicaid benefits vary within federal guidelines from state to state. The program also may be known as the Medical Assistance (MA) Program.

EPSDT - (Early and Periodic Screening, Diagnosis and Testing) - a special program provided for persons under 21 years of age who qualify for Medicaid. A series of screening tests are conducted by nurses and technicians to pick up abnormalities for referral to physicians for final diagnosis and treatment.

PSRO - (Professional Standards Review Organizations) - provided for under a 1972 Social Security Amendment, they are a formalized quality assessment system. Within the DHEW, the PSRO program is an inter-agency effort directed by the Office of Professional Standards Review (OPSR). The national office assists the state PSRO boards and those within the regions to establish regional norms for inpatient medical care. Reimbursement under federal programs (Medicare, Medicaid and Title V - maternal and child health programs) will be made subject to compliance of care with the standards. The standards are established and reviewed by osteopathic and medical doctors.

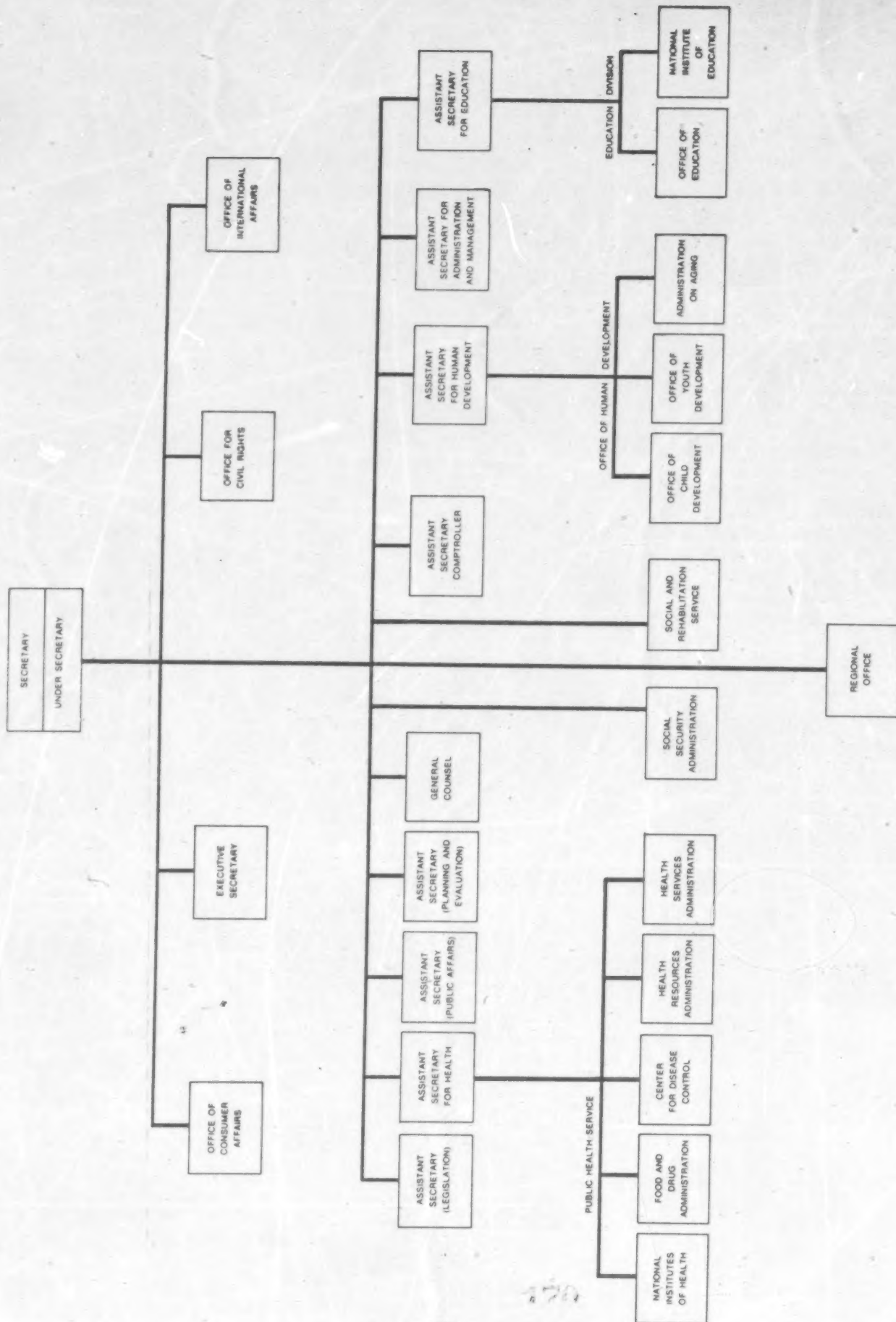
SSI - (Supplemental Security Income) - a new federal Social Security program of public assistance to persons eligible for public assistance payments under Old Age Assistance (OAA), Aid to the Blind (AB) and Aid to the Disabled (AD). In Michigan SSI payments are supplemented with state funds. The only major group still wholly paid for by state funds is Aid to Dependent Children (ADC) or Aid to Families with Dependent Children (AFDC).

Section 1122 of the Social Security Act - assures that funds spent under federal health programs, Title V (Crippled Children's and Maternal and Child Health funds), Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act, are not used to support unnecessary expenditures made by, or on behalf of, health care facilities or health maintenance organizations which are reimbursed by any of these titles.

Expenditures covered are those which, under generally accepted accounting principles, are not chargeable as expenses for operation and maintenance, and which: 1) exceed \$100,000; 2) change the bed capacity of the facility; or 3) substantially change services of the agency.

An areawide comprehensive health planning agency (314 "b") must review the plans for expenditure and make recommendations to the designated state review agency (in Michigan, the Health Facilities Commission of the Department of Public Health.) The review agency in turn makes recommendations to the Social Security Administration for appropriate action.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE



7

State Agencies, Programs and General Terminology

CHP - Comprehensive health planning - as a function was developed under Section 314 parts (a) - (e) of the Public Health Service Act. The section number and letter have been used as names for the agencies or functions they represent:

- 314 (a) funds are monies appropriated for establishing State Comprehensive Health Planning Agencies (also called "(a)" agencies). The Office of Health and Medical Affairs along with the Advisory Council constitute one such agency. In this state, the Office of Health and Medical Affairs functions as the single state agency for health planning and provides policy advice and consultation to the Governor. It also coordinates the planning of areawide agencies.
- 314 (b) funds are used to establish the ten areawide comprehensive health planning agencies ("(b)" agencies) in Michigan. They cover several counties each and coordinate existing and planned health services, manpower and facilities within their areas. They also provide review and comment under Act 256 and Section 1122.
- 314 (c) funds are intended for the education and training of persons and groups involved in the health planning process.
- 314 (d) formula grant funds awarded to the states to help establish and maintain a full range of public health services. Such grants give the states the opportunity to initiate new and different methods of providing health protection where innovation is needed, particularly where such services cannot be supported by existing funding sources. At least 15 percent of these funds must be spent in mental health.
- 314 (e) funds are for use in projects, especially in disadvantaged communities, designed to deliver comprehensive health services centered around programs of organized primary care.

MDSS - (Michigan Department of Social Services) - the department within the Michigan Government responsible for administration of state-funded medical and social services to the needy. The Medicaid program is administered by this department.

MDPH - (Michigan Department of Public Health) - the Michigan department responsible for licensing and issuing certificates of need for health care facilities, assessing quality of care under government sponsored programs, assuring control of communicable diseases and of environmental and industrial health hazards, collection of data relevant to the health status of Michigan's population and administration of health delivery programs for specific population groups such as mothers and children.

MDMH - (Michigan Department of Mental Health) - the state department which supervises state-owned hospitals and institutions for the mentally ill and mentally retarded, (MIMR), provides guidance and funding review for local Act 54 Boards, establishes standards for all institutions for MIMR and licenses non-state owned facilities.

Department of Human Services - is a new department created by Executive Order 1973-11, but is as yet unfunded, which seeks to combine the functions of all state agencies and commissions involved in providing some type of human service within a single, coordinated department. Included would be the Departments of Public Health, Social Services and Mental Health; the Indian Affairs Commission; the Office on Services to the Aging; the Michigan Economic Opportunity Office; the Manpower Planning Council; the Coordinated Child Care Council; certain rehabilitation programs from the Department of Education; and the Office of Health and Medical Affairs.

UMOI - (United Migrants for Opportunity, Inc.) - a federally funded non-profit organization serving the social service needs of agricultural migrant families.

MESH Council - (Michigan Emergency Services Health Council) - a completely volunteer organization of 145 representatives of agencies and organizations throughout Michigan involved in the delivery of emergency medical services (EMS). The council attempts to establish standards and procedures to improve the quality of EMS in Michigan.

HMO - (Health Maintenance Organization) - a relatively new concept in health care delivery utilizing pre-payment to a group of physicians who agree to deliver all needed care during the period paid for. In theory the physicians have a vested interest in maintaining their patient's health in order to keep down costs, especially to hold down expensive hospitalizations.

Incentive reimbursement - any of a number of methods of payment, usually to hospitals, which attempt to provide incentives to hold down the rate of increase in costs. The common reimbursement method is to pay hospitals for their costs plus a margin of surplus, thus providing no reason for the hospitals to hold down costs. One form of incentive reimbursement is prospective reimbursement under which 1) rates of payment are established in advance for some operating period, 2) then hospitals are paid these rates regardless of the costs they actually incur. Incentives (surpluses) and penalties (losses) operate to motivate cost containment activities.

Act 256, P.A. 1972 - state certificate of need legislation which requires health facilities to obtain a certificate of need from the State Health Facilities Commission of the Department of Public Health for "new construction or conversion, addition or modernization of health facilities." Prior to this step, the facilities must present their plans for expenditures to the local (b) agency for their recommendations which are presented with the plan to the Health Facilities Commission.

Provisions for fees and penalties for facilities not complying with the law are specified.

PBES - (Program Budget Evaluation System) - is Michigan's system for structuring the budgetary decision process in such a way that the focus of expenditure choices is upon whether or not the goals and objectives for the state are being met.

PPG - (Program Policy Guidelines) - annual documentation containing the Governor's direction and guidance to state governmental agencies for preparation of revisions to the Michigan Program Plan. (MPP). This includes program priorities, requirements for special studies and forecasts of major economic, demographic and social trends.

PRR - (Program Revision Request) - the documentation, usually from an operating agency, for a proposed specific change in the existing MPP.

MPP - (Michigan Program Plan) - the record of program planning decisions concerning the goals and objectives, the program performance measurements and the budgetary requirements to achieve the objectives.

Act 54 Boards - county established boards devised as an effort to coordinate county or multi-county mental health resources. The Boards, which are funded 75 percent by state funds and 25 percent by local monies, may provide any of the services or they may contract out for services. They coordinate in-patient, out-patient and partial hospitalization programs along county lines.

State Hospital Finance Authority - provides state monies to health care facilities for capital expenditures. Executive Order 1973-13 designated the State Health Planning Advisory Council as the agency to approve health facilities' applications, subject to prior granting of a certificate of need from the State Health Facilities Commission.

State Health Facilities Commission - is an eleven-member commission organized out of the Department of Public Health which "advises and consults with the Director" (of DPH) to implement Act 17 of 1968 (Hospital Licensing Law), Act 299 of 1947 as amended (Office of Hospital Survey and Construction), the requirement of P.L. 88-443 (Hill-Burton Law) and Act 256 of 1972 (Certificate of Need).

MEMORANDUM

State of Michigan
EXECUTIVE OFFICE

Office of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-7500
8155

To: Organizations Interested in the Delivery of
Maternal and Child Health Services

From: Robert J. Yellan, Staff Planner *RJY*
Office of Health and Medical Affairs

Subject: Preliminary Recommendations of the Maternal and
Child Health Task Force

Date: April 4, 1974

This is to follow-up on my earlier letter to you. Enclosed please find the preliminary recommendations of the Maternal and Child Health Task Force of the State Health Planning Advisory Council. These recommendations are an attempt to provide policy direction for the delivery of health services to mothers and children in Michigan.

The preliminary recommendations will be presented to the State Health Planning Advisory Council at their meeting on April 18, 1974. At this time, the Council's suggested modifications of the recommendations will be discussed.

We are also requesting comments and suggested modifications from various individuals and organizations throughout the state. The comments of your organization will be most helpful to the Maternal and Child Health Task Force.

As I explained in my earlier letter, if you would like to have an input into the Task Force recommendations, your response must be received by this office, in writing, no later than May 3, 1974. I realize that this gives a very limited time for review.

As you review these recommendations, please consider both the intent implied by the recommendations and the specific wording of the recommendations. If possible, endorsement by your organization of the intent of any or all of the preliminary recommendations would be extremely helpful to the Task Force.

Again, thank you for your assistance in this important area.

RJY:nh

MEMORANDUM

STATE OF MICHIGAN

DEPARTMENT OF MANAGEMENT AND BUDGET

LANSING

Date: June 27, 1974

To: Janet Coye

From: Bob Yellan

Subject: List of Contacts while working on the Task Force

At our meeting on May 17 we were asked to prepare a list of outside contacts in the Task Force work, so

1. Michigan Department of Public Health
 - Bureau of Maternal and Child Health
 - Bureau of Health Facilities
 - Bureau of Community Health
 - Office of Planning and Evaluation
2. Michigan Department of Social Services
3. Michigan Department of Mental Health
4. Michigan Department of Licensing and Regulation
5. Michigan Department of Civil Rights
6. Michigan Department of Education
7. Michigan Department of Commerce
8. Michigan House of Representatives
9. Michigan Senate
10. University of Michigan
 - School of Public Health
 - School of Medicine
 - School of Social Work
 - School of Nursing
 - School of Education
11. Southeastern Michigan Family Planning Project
12. 10 areawide comprehensive health planning agencies
13. Michigan Society of Obstetricians and Gynecologists
14. Michigan Chapter/American Academy of Pediatrics
15. Perinatal Association of Michigan
16. Wisconsin Perinatal Center
17. Bronson Methodist Hospital (Kalamazoo)
18. Greater Detroit Area Hospital Council
19. Michigan Nurses Association
20. Michigan Hospital Association
21. Michigan Association of Osteopathic Physicians and Surgeons
22. Children's Hospital of Michigan (Detroit)
23. Sparrow Hospital (Lansing)
24. Michigan State University
 - College of Human Medicine
 - College of Osteopathic Medicine

Janet Coye
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June 27, 1974

25. St. John Hospital (Detroit)
26. Hutzel Hospital (Detroit)
27. Beaumont Hospital (Royal Oak)
28. Port Huron Hospital (Port Huron)
29. Munson Medical Center (Traverse City)
30. Hurley Hospital (Flint)
31. Michigan State Medical Society
32. Wisconsin Division of Health Policy and Planning
33. University of North Carolina
 - School of Public Health
34. Michigan Consumers' Council
35. Michigan Womens' Commission
36. Michigan League for Human Services
37. Michigan Council on Children and Youth
38. Reproductive Health Services Accreditation Council
39. Planned Parenthood League of Detroit
40. American College of Obstetricians and Gynecologists
41. Health Insurance Association of America
42. Michigan Blue Cross-Blue Shield
43. American Hospital Association
44. U.S. PHA, Center for Disease Control
45. Planned Parenthood - World Population
46. Harvard University Child Health Project
47. Michigan Public Health Association
48. Michigan Health Officers Association

MEMORANDUM

State of Michigan
EXECUTIVE OFFICE

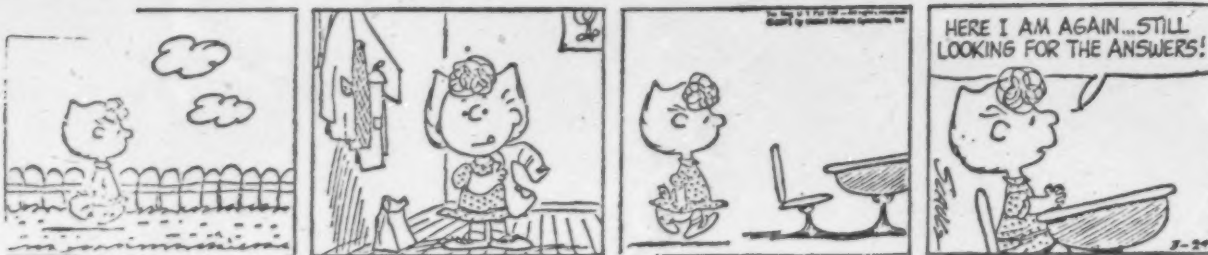
Office of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-7688

To: People In The Know About Long Term Care

Date: April 1, 1974

From: Carol Hesselbacher *CH*
Staff, Medicaid Task Force
State Health Planning Advisory Council

Subject: REVIEW OF DRAFT OF PRELIMINARY RECOMMENDATIONS



Enclosed you will find a copy of the preliminary recommendations of the Medicaid Task Force. They reflect the problems in current delivery of long term care as we have understood them. The Task Force would appreciate any recommendations for additions, deletions or changes you may wish to make.

Due to the time squeeze of Task Force deliberations, we would like to have your comments as soon as possible.

If you have any questions, please call me at (517) 373-8155.

CH:wh

enclosure

Organizations Requested to Review Medicaid Recommendations

- *10 "b" Agency Directors -
 - Senior Citizen's Fund
 - Westside Mothers
- *Office on Services to the Aging
- *Michigan Nurses Association
 - Lansing VNA
- *Detroit VNA
- *Homemakers Upjohn
- *Blue Cross of Michigan - Norma Beerweiler, Home Care Administrator,
also is head of Council of Home Health Nursing of MNA (title may be wrong)
- *Nursing Section, MDPH - Claire Corriveau & Pat Hatfield
- *Citizens for Better Care, Inc.
- *University of Michigan - Institute of Gerontology - Jane Barney
- *Wayne State University - Institute of Gerontology - Jeanne Fitzgerald
- Michigan Nursing Home Association
- Michigan State Medical Society - Herbert Mehler, Director
- Michigan Ass'n. of Osteopathic Physicians and Surgeons - Robert Herrick, D.O.
- *Michigan Department of Public Health - M. Reizen & L. Lamont
- *Michigan Department of Social Services - R. B. Houston & S. Paterson
- Blue Cross of Michigan - V.P. for Gov't. Affairs - G. P. Kearney, Jr.

* Responses Received

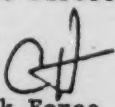
MEMORANDUM

State of Michigan
EXECUTIVE OFFICE

Office of Health and Medical Affairs
Lewis Cass Building
Lansing, Michigan 48913
Telephone (517) 373-7688

To: (B) Agency Executive Directors

Date: April 1, 1974

From: Carol Hesselbacher 
Staff, Medicaid Task Force

Subject: Review of Preliminary Recommendations of the Medicaid Task Force

Enclosed you will find a copy of the preliminary recommendations of the Medicaid Task Force. A number of the recommendations relate specifically to activities of your agency. In addition, it has been suggested that the (b) agencies should appoint assessment and placement agencies within their regions, rather than to automatically designate the certified home health providers as stated in Recommendations #1.

The Task Force has asked to have your comments and opinions on the recommendations. I am sure you know of our time squeeze, so I hope you will respond soon.

If you have any questions, please call me at (517) 373-8155.

CH:wh

enclosure

Listing of Organizations Contacted by the Health Cost Containment
Task Force

Colleges, Universities, and Educational Groups

Department of Community Medicine
College of Osteopathic Medicine
Michigan State University

School of Public Health
Program and Bureau of Hospital Administration
University of Michigan

Medical School
University of Michigan

Delta College

Macomb County Community College

W. K. Kellogg Foundation

Third Party Payers

Michigan Blue Cross

Health Research Division
Department of Social Services
State of Michigan

Division of Special Operations
Bureau of Health Insurance
Social Security Administration
DHEW

State Government

Bureau of the Budget
Department of Management and Budget

Health Care Service Plans Division
Insurance Bureau
Commerce Department

Other States

Wisconsin Regional Medical Programs

Health Care Organizations and Associations, and Community Agencies

Michigan Hospital Association

Michigan Association of Osteopathic Physicians and Surgeons

Veteran Hospital, Ann Arbor

Provincial House, Inc.

Capitol Area CHP

South Central Michigan CHP

Menominee-Delta-Schoolcraft Community Action Agency

Baldwin Community Action Agency

Health Action League, Lansing

Private Industry

Industrial Relations

Ford Motor Co.

Research and Engineering

Whirlpool Corp.

Steelcase, Inc.

Balfour-Stulen Corp.

MATERNAL AND CHILD HEALTH TASK FORCE RECOMMENDATIONS

WORKSHEET

May 16, 1974

(For use as your guide at the Advisory Council discussions)

	<u>SUPPORT</u>	<u>OPPOSE</u>	<u>QUESTIONS</u>	<u>COMMENTS</u>
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	<u>SUPPORT</u>	<u>OPPOSE</u>	<u>QUESTIONS</u>	<u>COMMENTS</u>
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MEDICAID TASK FORCE RECOMMENDATIONS

WORKSHEET

May 16, 1974

(For use as your guide at the Advisory Council discussions)

	<u>SUPPORT</u>	<u>OPPOSE</u>	<u>QUESTIONS</u>	<u>COMMENTS</u>
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HEALTH COST CONTAINMENT TASK FORCE RECOMMENDATIONS

WORKSHEET

May 16, 1974

(For use as your guide at the Advisory Council discussions)

	<u>SUPPORT</u>	<u>OPPOSE</u>	<u>QUESTIONS</u>	<u>COMMENTS</u>
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